IN THE WAKE OF STRUCTURAL ADJUSTMENT PROGRAMS: EXPLORING THE RELATIONSHIP BETWEEN DOMESTIC POLICIES AND HEALTH IN ARGENTINA AND URUGUAY

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ABSTRACT

Background: The implementation of structural adjustment programs (SAPs) in low to middle income (LMICs) has been followed by a marked reduction in their progress on economic growth, social indicators and health outcomes. Comprehensive and contextualized explorations of the effects of SAPs are needed to assist health and social policy-makers in better determining responses to such programs that continue to dominate global trade, aid and debt cancellation negotiations.

Methods: A comparative case study of Argentina and Uruguay was developed exploring the effects of SAPs on health. Drawing from a population health perspective and using a framework developed to analyze the relationship between globalization and health, changes in domestic policies resulting from SAPs and the corresponding population health outcomes of the countries were explored.

Results: In general, SAPs were implemented with greater severity and speed in Argentina than in Uruguay, with the greatest differences occurring over the 1980s. The more gradual and modest reforms implemented in Uruguay over the 1980s were associated with better population health outcomes. As Uruguay's reforms began to accelerate and more closely resemble Argentina's over the 1990s, differences in population health of the countries were diminished.

Conclusions: Findings support those of previous studies demonstrating that countries that have maintained more protectionist policies have been better able to protect the health of the most vulnerable sectors of society.

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LIST OF ABBREVIATIONS

Abbreviation	Definition
CHA	Comparative Historical Analysis
CET	Common External Tariff
CPI	Consumer Price Index
CNT	Comision Nacional de Telecomunicaciones
DISSE	Direccion de los Segouros Sociales por Enfermedad
ECLAC	Economic Commission for Latin America and the Caribbean
GATS	General Agreement on Trades in Services
GDP	Gross Domestic Product
GNI	Gross National Income
GNP	Gross National Product
HIPIC	Heavily Indebted Poor Countries
HIC	High Income Countries
IFIs	International Financial Institutions
IMF	International Monetary Fund
ILPE	Industria Lobera y Pesquera del Estado
IMR	Infant Mortality Rate
IAMCs	Institutos de Asistencia Medica Colectiva
ISI	Import Substitution Industrialization
LIC	Low Income Countries
LMC	Lower Middle Income Countries
LMICs	Low-Middle Income Countries
PAHO	Pan American Health Organization
PRSPs	Poverty Reduction Strategy Papers
SAPs	Structural Adjustment Programs
UMC	Upper Middle Income Countries
<5MR	Under Five Mortality Rate
UNICEF	United Nations International Children's Emergency Fund
US	United States
US$	United States Dollar
WB	World Bank
WTO	World Trade Organization

Chapter 1 Introduction and Background

Globalization has led to a number of important population health-related economic policies (1-3). While globalization may not be a new phenomenon, the pace, intensity, and scale of its impact across all societies has substantially accelerated(2). Contemporary globalization is distinguished by the establishment of binding agreements through the World Trade Organization (WTO), the emergence of economically powerful trans-national companies, and the growing acceptance by countries of a neoliberal agenda marked by increased market liberalization and reduced interference by the state. A central mechanism through which globalization has been spread is the implementation of structural adjustment programs (SAPs) in low to middle income countries (LMICs)[1].

SAPs were a set of economic and public policy conditions imposed by the International Monetary Fund (IMF) and World Bank (WB) on indebted LMICs (2,4-6). They were intended to ensure macroeconomic stability, control runaway inflation and permit governments to maintain interest payments on national loans owed to banks and development agencies in high income countries (HIC). While there is still much disagreement around the impact of SAPs on health, there is growing evidence that LMICs have suffered a decline in economic growth, health and social progress since their introduction (2,4,7-10). In particular, SAPs have been critiqued for their role in exacerbating poverty and inequality while accelerating environmental degradation (1,11-13).

[1] This document uses the World Bank categories to denote country differences. Countries are organized according to per capita gross national income (GNI) levels calculated using the World Bank Atlas Method. The groups are: low income (LIC); lower middle income (LMC); upper middle income (UMC); and high income (HIC). See: The World Bank Group. Data & Statistics: Country Classification. 2007 [cited 2007 17 August]; Document on internet] Available from: http://go.worldbank.org/K2CKM78CC0.

SAPs weak growth performance and, in some cases, propensity to worsen the living conditions of the poor over the 1980s and 1990s led to the recognition that alternative policies were needed(7,14-16). To this end, Poverty Reduction Strategy Papers (PRSPs) were introduced in 1999, with innovative elements such as participation of civil society and a focus on governance and alternative social policies (14). Disappointingly, however, despite this commitment to a new approach, the macroeconomic policies adopted by the majority of the PRSP countries have basically resulted in a continuation of SAPs (7). As PRSPs are required before countries can receive debt relief under the Heavily Indebted Poor Countries (HIPIC) initiative, and, increasingly, for bilateral development assistance or concessional loans from the World Bank, they continue to significantly propagate the economic neoliberalism underlying SAPs (1,15). So while SAPs no longer exist in name, their successor continues to embody most of SAPs' economic framework.

This neoliberal economic framework extends beyond the boundaries of agreements signed under SAPs and PRSPs. SAPs embody many of the economic policies of contemporary globalization, which have repercussions for Canada and the world (4,6,17-19). Liberalization, for example, while one of SAPs' conditions, is now binding on most of the world's countries through the agreements of the WTO (20). With increasing economic interdependence has come a reduction in the authority of national governments over their social and environmental regulatory space (4,17,19,21). As with LMIC's involvement with SAPs, Canada's participation in agreements such as the Canada-US Free Trade Agreement, NAFTA, and the WTO's agreements raises concerns that governments will no longer be able to enact or maintain policies that protect the health and equity of their citizens (17). A retrospective look at the twenty years experience of increased liberalization, privatization and market integration policies of the SAPs that were imposed on LMICs gives insight into the

potential health implications of trade agreements that most high, middle and low income countries have been and are continuing to voluntarily enter into (17). Thus, an examination of SAPs effects on health holds important lessons for current and future global population health.

Latin America was a key region of the world in which SAPs were imposed, and serious political, economic and social problems have emerged (10,16,22). Since the mid-1980s, the neoliberal economic and political ideas on which SAPs were based have become the norm throughout Latin America[2] (4,5). This transition has been accompanied by growing political, social and economic critiques. Political power, for instance, has been restructured to allow the agenda of business and financial agents to take precedence over labour and other societal interests causing concern about its effects on issues such as poverty, environmental degradation and income inequality. Along with social problems, neoliberal reforms have generated disappointing economic results in Latin America in terms of growth and stability, as demonstrated by the debilitating hyperinflation of the early 1990s (23). Politically neoliberal reforms have also promulgated the installation of neopopulist, quasi-authoritarian governments (such as the Menem government in Argentina, Fujimori in Peru and Caldera in Venezuela) leading to public outcries demanding attention to issues of accountability and transparency, judicial reform, corruption, and human rights. The emergence of serious social problems and the persistence of economic and political problems have prompted a significant questioning of SAPs' neoliberal orientation and provoked a need for more research into the ways in which it can be altered to address these shortcomings.

[2] A notable exception is Cuba

While SAPs followed a neoliberal paradigm, the degree to which these reforms were adopted varied across countries. Factors such as popular resistance, policy preference of national decision-makers, and the perceived need to implement macroeconomic policies that would attract foreign investment affected the extent to which countries' policy reforms reflected the neoliberal prescriptions found in SAPs (1,15,24). These differences in policies adopted in countries during the implementation of SAPs offer a unique opportunity to retrospectively explore if and how these variations differentially affected their health. As will be discussed in the fourth chapter Argentina and Uruguay in particular provide ideal country cases as they embody sufficient contextual similarities and differences in their implementation of SAPs to allow for a meaningful contrast of the effects of these policies on their economic, social and health outcomes. Such a comparison can assist health policy-makers to better formulate responses to the neoliberal economic framework which informed SAPs and PRSPs and which continue to dominate global trade, aid and debt cancellation negotiations. Given the importance of future research that provides contextualized examinations of the impact of neoliberal policies on health, the overarching research question guiding the study was: *How did differences in the implementation of SAPs and the attendant domestic policy reforms in the 1980s and 1990s differentially affect the population health of Argentina and Uruguay*?

1.1 Study Approach

This study examines the effects of SAPs on Argentina and Uruguay from a population health perspective through the use of an analytical framework that links global policies to local health outcomes. The following section provides an overview of the concepts of population health and explores the dimensions and levels of the analytical framework.

1.1.1 A Population Health Approach

Population health is a perspective that encompasses the consideration of interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of populations (25). Population health is focused not only on observing what are the patterns, conditions and factors associated with health but also questions how these patterns came to be, what are the mechanisms producing these patterns, and why they exist (26,27). Population health is a proactive rather than reactive approach to health that seeks to create positive environments that promote health by addressing the distal sources or underlying health producing contexts rather than intervening only after health problems have arisen (28).

As a field, population health is interdisciplinary and intersectoral in its approach, spanning traditional academic disciplinary boundaries, communities and sectors within society (25). Accordingly, it takes a broad multidimensional perspective to its understanding of health that acknowledges the importance of a wide spectrum of social, economic, political, environmental and structural determinants of health operating at the macro and micro level of the population (26,29,30). From a population health perspective, the factors that determine health go beyond the dominant modern medical paradigm that views health primarily as a consequence of biological or lifestyle factors and places responsibility for health on the health care system and individual lifestyle choices (31). Rather, health is seen as determined by a complex array of interconnected social, economic and political determinants that require intersectoral responses at individual, community, domestic and macroeconomic levels (25,26,29,32). Thus population health recognises a diverse range of social, political,

and economic determinants of health; considers their interaction with the global and local historical contexts in which they occur; and sees health as an outcome influenced and measured by this complex relationship.

1.1.2 A Population Health Perspective of SAPs

SAPs, and more broadly neoliberalism, are touted to have many positive effects on health through their purported stimulation of economic growth and poverty alleviation(30). Despite these claims, growing evidence demonstrates that neoliberalism has substantially hindered economic growth and that even when growth has occurred the benefits have been highly skewed in favour of the wealthy (33,34). A key problem underlying this discrepancy arises from the manner in which SAPs have been evaluated. Advocates of SAPs have often limited their analysis of their impacts on health to a simplistic growth = health equation (30,35,36). Ignored in this narrow emphasis on aggregate measures of wealth is the recognition that health is a product of a broad spectrum of health determinants. Income inequality, the erosion of public health systems and social protection, for instance, have all been shown to have important connections to health and have also all suffered under the imposition of neoliberal policies (32). An examination of SAPs from a population health perspective, in contrast, requires focusing on a wide spectrum of economic and social health determinants.

1.2 A Framework for Globalization and Health

Accompanying the growing need to examine SAPs from a population health perspective has been the increasing awareness of the inadequacy of models that can be used to trace its effects on health (1,37,38). Quite often, political economists ignore micro level analysis while social and health academics are criticized for failing to address the underlying macro causes of health problems (39). This tension has led to a search for research

frameworks that can better understand and explain the effects of macroeconomic policies on the population health within countries(38). Practical models that encompass a broad range of health determinants and identify the specific pathways through which macro-level economic policies affect micro-level health outcomes are needed if policy makers are to be able to better address the growing health concerns surrounding these economic policies (1,37,38).

This study sought to explore the effects of the macroeconomic policy interventions of SAPs on the population health of Argentina and Uruguay by adopting a framework that traces the connections between globalization and health(37) (See figure 1). The framework begins with three cascading categories (spanning super-ordinate to domestic contexts) that help depict how globalization is linked to the national policies of countries. At a super-ordinate level the categories *pre-existing endowments* captures the historical context of the country (e.g. political, social, and economic traditions) as well as their accumulation of pre-existing endowments (e.g. economic development level, human capital development). These endowments were present prior to the imposition of contemporary globalization and thus shape how globalization manifests itself and consequently affects health outcomes. At the global level, *macroeconomic policies*, represent the primary vehicles through which contemporary globalization is disseminated. This category encompasses policies such as SAPs (the focus of this study) and their replacement PRSPs, enforceable trade agreements, official development assistance and the multiple agreements on human rights such as environmental protection, and women and children's rights. The effect of macroeconomic policies on health were than traced to their impact on domestic policies which in this study were represented by economic (trade, privatization), social (labour market, pensions) and health (health care systems) sectors. Changes and restrictions to national government's ability to make autonomous decisions as a result of bi-directional conditionalities from loan,

aid, debt forgiveness or trade agreement commitments push policy directions in countries toward a neoliberal model.

Next the framework narrows its focus to a detailed exploration of the effects of domestic reforms on their corresponding outcomes in each sector. The effects of reforms range from the national to the local level depending on the sector examined. Trade reforms are linked to their effects on trade balance, export and import growth; privatization reforms to consumer costs and service delivery, political effects, and long and short-term economic effects; labour market reforms to per capita income, real wages, unemployment, precarious employment, and underemployment; pensions to fiscal costs, administrative costs, domestic savings, compliance, coverage, inequities and gender; and health care system reforms to coverage, inequities, and cost containment. This sample of effects provides a snapshot of the complex and interconnected pathways by which domestic policy reforms affect the economic, social, and health conditions of countries.

Finally the framework broadens its focus to an examination of the cumulative population health effects of reforms represented by the circular figure on the left side of the diagram. The outer ring of the circle represents the economic (GDP, inflation, debt) and social (inequality, poverty) population health determinants and the inside circle the health outcomes (infant mortality and under five mortality) of the countries. The economic and social determinants of health and the corresponding health outcomes provide an overall picture of the population health of the country. Population health is thus the result of bi-directional interactions of multiple processes and forces from the global to household level.

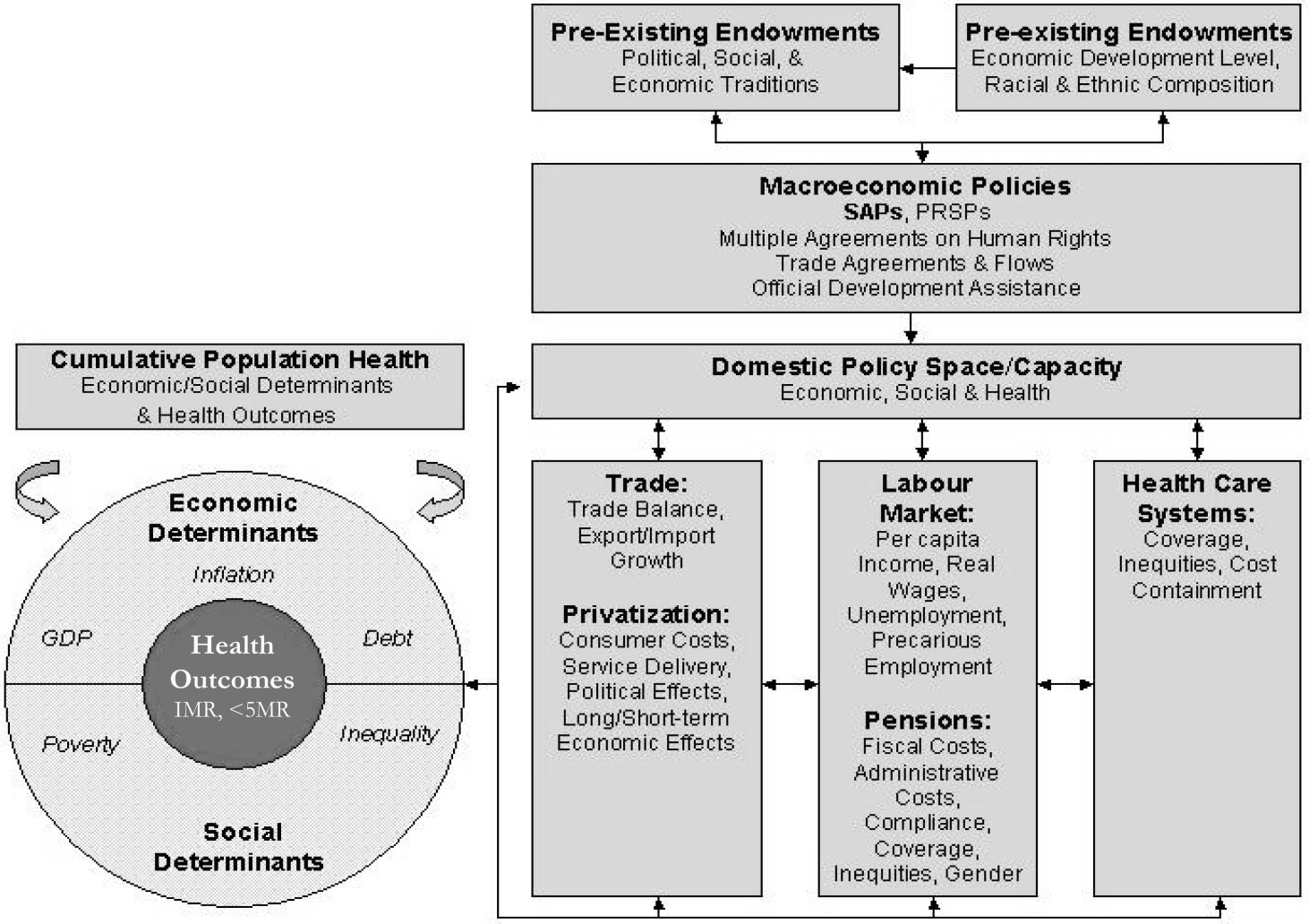

Figure 1: Globalization and Health Framework

This analytical framework is used to guide the exploration of the effects of SAPs on the population health of Argentina and Uruguay. The following Chapter examines the historical development of neoliberalism and SAPs and explores the relationship between SAPs' economic reforms and health. Chapter 3 provides an overview of the methodological approach and incorporation of the analytical framework used to guide this study. Chapter 4 presents an analysis of the reforms to domestic policies and their effects on the corresponding sector through an analysis of a comprehensive body of literature and selected data sources. Chapter 5 explores the cumulative population health effects of these reforms through an examination of economic and social determinants of health and their corresponding effects on health outcomes. Chapter 6 concludes the thesis with a discussion of the results, their significance for the future study of neoliberal economic globalization, and the strengths and weaknesses of the study.

CHAPTER 2 SAPs, The Rise of Neoliberalism, & The Ongoing Health Debate

This chapter describes and analyses important contextual aspects leading to the implementation of SAPs and discusses the relationship between key structural adjustment reforms and health. The reforms examined represent a diverse sample of economic, social, and health policy areas including: trade, privatisation, labour market, pensions and health systems. By exploring a diverse body of literature SAPs is situated in the context of the historical development of neoliberalism and the health arguments for and against the neoliberal reforms advocated for under SAPs are examined.

2.1 Paving the way for Neoliberalism through and with SAPs

While differences in the implementation of SAPs may allow the countries' reforms to be compared, it is difficult to differentiate between neoliberal reforms implemented due to SAPs and those voluntarily taken on by national governments (16,34,37). This difficulty is in some regards a negligible issue, as SAPs were implemented with the intention of entrenching a neoliberal perspective on the economic policy of the countries in which they were imposed. 'Voluntary' adoptions of such policies can thereby be seen as a by- product of the successful diffusion of SAPs market-oriented principles. So, while the motivations for adopting neoliberal reforms can't be easily distinguished, the imposition of SAPs can be considered the central force driving LMICs' transitions from protectionist to neoliberalist economic and political models (22,40). The following is an examination of SAPs' foundations in, and utilization as a vehicle for the dissemination of, neoliberal policies in LMICs.

Neoliberalism is a theory of political economic practices proposing that human well-being can best be advanced by the maximization of entrepreneurial freedoms within an

institutional framework characterized by private property rights, individual liberty, unencumbered markets, and free trade (34). The role of the state in this model is to create and preserve an institutional framework supportive to such practices. SAPs advanced this perspective by advocating for multiple domestic policies aimed at integrating national economies into the global marketplace and reducing the interference of the state (4,41). These market-oriented domestic policies included fiscal austerity, trade liberalization and currency devaluation, retrenchment and deregulation, and the privatization of state-owned enterprises (4).

SAPs were not only based on a neoliberal paradigm but were imposed with the intention of entrenching neoliberal policies in LMICs. One reason for this push was the perceived threat to the political and economic interests of capitalist elites in the 1970s (34). Prior to that time and since the Second World War, import substitution industrialization (ISI)[3] had been the dominant development approach prevailing in LMICs (4,40,42-46). ISI threatened the economic supremacy of capitalist elites because it restrained the economic power of the upper classes and accorded labour a much larger share in the division of wealth (34). With the world recession of the early 1970s, this economic squeeze became more apparent and ruling classes were further threatened by a resurgence of communist and socialist powers responding to the economic problems of the time (34).

[3] ISI policies were an economic development approach that encouraged the local production of previously imported manufactured goods. A major impetus toward Latin American countries adopting ISI was the Great Depression of the 1930s when commodity prices fell and world demand dropped off. Economic development could not be guaranteed through exporting primary commodities so a form of industrialization was necessary. This strategy relied heavily on the intervention by the state to control trade and investment through protective measures such as tariffs and quotas as well as involving corporatist labour relations with the trade unions who supported these national projects.

As capitalists felt increasingly vulnerable, they sought an economic approach that was more in line with their interests. It was found in the teachings of a group of economists called the "Chicago boys" who espoused the neoliberal theories of Milton Friedman (34). Friedman revitalized liberal economic teachings[4] that had dominated US economic policies from the late 1700s to the time they were discredited during the Great Depression. Milton's neoliberalist theories maintained much of liberalism's market-oriented stance but modified small aspects which he saw as having led to the economic problems of the Great Depression[5] (47). In order to give credibility to these newly restored theories Chile was used as an experimental location in which to demonstrate their effectiveness. A coup d'etat in Chile in 1973, strongly backed by the CIA and U.S. Secretary of State Henry Kissinger, was initiated to replace the socialist president Salvador Allende with neoliberal dictator Augusto Pinochet. Chile's subsequent economic growth, which ironically was accompanied by an unacknowledged increase in inequality and poverty, provided the justification for the neoliberal policies later adopted in the late 1970s and early 1980s in Britain (under Thatcher) and the United States (under Reagan) (47,48). The debt crisis following the collapse of the second oil boom in 1981 then provided an opportune moment in which to further spread neoliberal economic policies in LMICs.

While the 1970s set the stage for a neoliberal revolution, a debt crisis in resource-based economies, especially in Latin America, initiated a radical sequence of events that

[4] Liberal economic thought was developed by a Scottish economist Adam Smith in the late 1700s.

[5] Milton modified the old quantity theory of money and replaced it with monetarist theory. Monetarist theory sought to change what was seen as the overly restrictive policies of the Federal Reserve Bank and the U.S. Central Bank. Milton thought that the previous overproduction crises and periods of inflation and deflation of the Great Depression were caused by fluctuations in the money supply and could be avoided if the Federal Reserve were required to increase the money supply at the same rate as the estimated growth of real economic output.

demolished protectionist policies and implemented neoliberal economic approaches in these indebted countries (4,42). The debt crisis was unanticipated and threatened the collapse of confidence in one or more of the major US banks(49). The US Treasury, the Federal Reserve Board and the IMF took political control of the crisis and pressured small banks to maintain additional loans to indebted countries despite their desire to withdraw. Despite other significant external factors (e.g. oil crisis, rising interest rates) protectionist policies were blamed for the economic crisis, and the IMF and the World Bank were brought in to reorganize debtor economies based on the neoliberal paradigm (4,49).

New loans and the rescheduling of old loans were made dependent on conditionality agreements that imposed a neoliberal agenda. Those countries that challenged the legitimacy of complying with the debt repayment plans were intimidated into complying with threats of economic reprisal (4,49). In a speech to the US Chamber of commerce in 1983, the US Treasurer, Robert McNamara outlined the sanctions available against a defaulter. McNamara stated that "the foreign assets of a country would be attacked by creditors throughout the world: its exports would be seized by creditors at each dock where they landed, its national airlines unable to operate and its sources of desperately needed capital goods and spare parts virtually eliminated" and that "in many countries even food imports would be curtailed" (4). Failure to get an IMF loan due to rejection of a SAP package would have also been taken as a sign of fiscal instability, leading to international bond raters giving the country a very poor rating and consequently raising the interest cost substantially for countries wishing to borrow from private international creditors(50,51). In this way, the debt crisis and subsequent enforcement of SAP conditionalities facilitated both the transition to and entrenchment of neoliberalism as *the* dominant economic approach in LMICs.

2.2 Neoliberal Reforms and Health

Accompanying the growth of neoliberalism as the hegemonic economic approach in LMICs has been the increasing awareness of the inability of many countries to protect and promote health(52). In this study the health effects of a broad range of economic (i.e. trade, privatization), social (i.e. labour market, pension) and health (i.e. healthcare systems) policy reforms are explored. This exploration does not represent an exhaustive list of neoliberal reforms adopted in Argentina and Uruguay under SAPs; but rather provides a representative sample of the differences in intensity and comprehensiveness of the reforms undertaken in the countries. More importantly, the reform areas examined encompass key examples of both distal[6] (economic, social) and proximate[7] health determinants (health care systems) (See table 2.1) (53). The following section provides a discussion of the policy reforms examined in this study and their importance as health determinants.

Table 2.1: Distal and Proximate Health Determinants

Distal Determinants
Economic Reforms ▪ Trade Liberalization ▪ Privatization
Social Reforms ▪ Labour Market ▪ Pensions

[6] Distal determinants are health determinants at the most distant point from the health outcome in the chain of causality.
[7] Proximate determinants are health determinants at the closest point to the health outcome in the chain of causality.

Proximate Determinants
Health Reforms ▪ Health Care Systems

2.2.1 Trade Reform and Health: Perpetuating Poverty

The relationship between trade and health is a widely debated topic with proponents and critics both mustering evidence for their claims (1,17,54). From the dominant neoliberal perspective, integration into the world economy through trade is thought to promote economic growth thereby reducing poverty and consequently improving health (55). SAPs generally include reforms pushing trade liberalization, which involves the reduction of barriers, such as tariffs, import quotas and restrictions on foreign investment, in order to allow for the free flow of goods and services.

The proposed economic advantages of trade liberalization lay in its ability to drive down the costs of inputs for exportable manufactured products, thus increasing exports and easing the scarcity of foreign exchange (41). In addition, trade liberalization is argued to increase productivity by exposing previously protected industries to competition. In the context of rapidly rising prices, trade liberalization is intended to curb inflation by increasing competition from imports, preventing price increases due to monopolization. These conditions should theoretically enhance the 'natural' comparative advantage of the economy in which a country increases growth and efficiency by specializing in the production of goods that it is able to produce at a lower cost than a competitor.

Critics of this theory argue that economic growth is not a predictable consequence of increased openness to trade and highlight the flaws of the argument that economic growth automatically leads to poverty reduction and health, particularly in the absence of

redistributive mechanisms (56). In reality, the effects of trade liberalization cannot be oversimplified as either positive or negative. A closer look reveals that trade liberalization may aid producers already involved in the cash economy, while subsistence farmers, for example, benefit little and may even be harmed by increased trade (1,56). Some trade also has clearly negative ecological consequences that undermine its economic benefits. Irrigation of land and toxic fertilizer and pesticide runoff, for example, may increase agricultural production but can also compromise access to potable water (56).

While the effects of trade liberalization on health are unpredictable, much evidence points to disproportionate losses amongst many LMICs, and particularly for the poor within them (1,55). International trade has been accompanied by the rise of dominant nation-states that use their power to influence the terms of trade (i.e. trade agreements) in their favour. Unfair trade rules, for instance, encourage the reduction of trade barriers in developing nations while maintaining protection in developed countries (e.g. agricultural subsides in industrialized nations) (1,55). When LMICs seek access to northern markets, they face trade barriers that, on average, are four times higher than those applied when HIC income countries trade with each other (57). Trade restrictions are also concentrated in the areas in which the poor stand to benefit, such as textiles, garments and agriculture. International trade rules further retain high tariffs for value added products and low barriers to primary products, locking LMICs into the exportation of low value-added goods that produce limited technology transfer and have negligible links to the local economy (1,57). In addition, trade liberalization has been found to encourage large-scale, often foreign-owned and operated firms that have undermined small domestic businesses and industries, leading to increasing inequalities(18). Chen and Berlinguer write that the wealth arising from increased global

trade is becoming more and more concentrated in the hands of a "transnational elite" who are "becoming less responsive or obligated to the socially underprivileged" (30).

A number of other indirect connections between trade and health exist. The rise of food exports from LMICs has also lead to food security issues that especially affect the poor (56). Additionally, questions of the gendered affects of trade liberalization have also arisen. Women, for instance, are thought to be particularly affected by trade liberalization as the decline in domestic food availability increases women's labour time in household food production. Trade liberalization therefore, is a complex and unpredictable policy measure that has the potential to result in economic gains for some; but these gains may be at the expense of many LMIC populations, the environment, women and the poor.

2.2.2 Privatization and Health: Profit vs Equity and Public Welfare

The relationship between privatization and health determinants is similarly complex and disputed. Privatization means that services, utilities or other companies owned and maintained by the public (through the government) are made available for purchase to private bidders(58). Advocates of privatization argue its health benefits based on purported economic improvements (59). The privatization of public goods in Latin America began in the 1970s in Chile and in the 1990s spread through most of the region, often as part of SAPs' conditionalities . The privatization of a public monopoly (electricity, for example) opened the market to multiple companies, created competition and supposedly contributed to greater efficiency within the market (60). In addition to increased efficiency, privatization was also intended to raise money for governments that were desperately in need of it and to reduce the fiscal burden of public enterprises (thus enabling them to meet their foreign debt repayments)(58). Privatization, from this perspective, improved the economic profitability of

industries, the quality and cost of services for consumers and helped maintain foreign debt payments (60).

Critics of this view counter that in reality privatization eroded health because it placed unwarranted trust in the market's ability to equitably allocate resources(35). While theoretically privatization intended to improve competition (and as a result to improve the affordability and quality of services), opponents argue that in actuality it encouraged the domination of markets and undermined the efficiency it was intended to promote(61,62). Teeple writes that the idea of free markets that encourage competition is an illusion masking "cartelization[8], monopolization, and oligopolization[9]" (19,61,62). As privatization increased, critics feared that public well-being would be sacrificed at the expense of corporate profits. The increasing privatization of water, for example, led to the control of 70 percent of water service in the world by two companies whose profits exceeded more than most of the national economies in which they operated (63). These profits were accompanied by rate hikes, cut offs to customers who couldn't pay and reduced water quality. The poor were further claimed to have suffered under privatization as government driven equity enhancing policies, such as cross-subsidization[10] of public utilities (e.g. water, sanitation, electricity), were eliminated (35,64). The shift to a market ideology was thus argued to jeopardize population health by eroding societies' collective sense of responsibility for public welfare and replacing it with a naive faith in an unregulated private sector (65,66).

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[8] Cartelization is the uniting of large numbers of sellers to reduce competition and raise prices.

[9] Oligopolization is corporate consolidation (mergers, acquisitions, takeovers, and buyouts) that leads to reduced competition, surplus profits and price collusion.

[10] Cross-subsidization can take two forms: lower costs for less affluent consumers or domestic customers compensated by higher costs to more affluent or industrial consumers; or the use of profits from one state-owned sector (e.g. telecommunications) to subsidize the costs of another state-owned sector (e.g. health care or water).

2.2.3 Labour Market Policies

The labour market has been recognized as one of the main links between the economy and health, as it has an impact on employment, wages, working conditions, income distribution and poverty(67). Employment conditions have a significant effect on a person's physical, mental and social health(68). Paid work provides not only money, but social contacts, opportunities for personal growth and a sense of identity and purpose. Higher incomes are associated with a greater degree of control over one's life and especially over stressful situations, which has a strong positive influence on health. Losing employment and income can have serious consequences for an individual, such as a reduced life expectancy and significantly greater health problems, than those who have work. Individual unemployment and high societal levels of unemployment not only affect those without work, but have wider impacts on their families and their communities. Women in particular, suffer from unique stresses during periods of high unemployment or reduced income as they frequently compensate by seeking work outside the home while simultaneously maintaining their work in the home.

While it is generally acknowledged that conditions of the labour market play a significant role in determining health, the health effects of neoliberal versus protectionist approaches to labour policy are strongly disputed (69,70). At the start of the 1980s, in the context of the debt crisis, adopting market driven labour policies that promoted flexible employment conditions came to be considered a necessary condition for increasing productivity and allowing businesses to compete in a changing global market (69-71). The proposed health benefits of labour market reform resided largely in its supposed economic advantages in promoting the external competitiveness of industries, contributing to maintaining price stability and stimulating employment (72). Advocates of labour market

reform sought to reduce protective labour legislation (governing wages, working conditions or labour rights more generally) and lessen union involvement in collective bargaining because they were argued to create rigidities, which were harmful to enterprise competitiveness and discouraged job creation (72). From a neoliberal view protectionist approaches hindered employment by preventing wages from falling and jeopardized industry competitiveness by making it costly to reduce employment when it was required by changing economic conditions (73). Unions and protectionist policies, it was argued, also hindered efficiency by resisting streamlining production, improving technology and changing outdated job descriptions and occupational jurisdictions (72,73).

In contrast to these dominant pro-market views, critics countered that neoliberal labour reforms offered short-term economic benefits and increased employment, but that these 'benefits' would result in low quality jobs and social and economic instability. Advocates of protectionist policies claimed that constraints on wages and dismissals improved rather than harmed efficiency and employment. Labour regulations restrain unemployment growth during recessions, stabilize labour demand in the longer term, encourage workers' commitment to enterprise success, induce employers to provide and workers to acquire firm-specific training and skills, and promote cooperative relations in the workplace (74).

Opponents of neoliberal labour reform further argued that flexible employment had unaccounted-for adverse affects on the mental and physical health of workers. Precarious employment, for instance, could lead to a lack of income, a loss of social support networks, and lowered self-esteem (71). Temporary workers were found to have unhealthy lifestyles characterized by greater cigarette and alcohol consumption, less exercise and significantly higher mortality rates in comparison to permanent workers. Health inequalities also

increased under flexible employment conditions as uneducated and low income employees were most often the targets of job cuts (71,75). Neoliberal labour market reforms, then, were argued to offer short-term economic solutions that undermined social and health conditions and long-term economic stability.

2.2.4 Pension policies

Pensions, like income, are an important determinant of health because they have broad psychological and physical ramifications for recipients. Pensions affect the ability of beneficiaries to pay for necessities such as clothing, food and housing, and can contribute to a sense of security and well being for recipients (67). The lack of an adequate pension can also negatively affect the health of the wider family, who may be the only support for an elderly family member. On a broader level pension systems play a significant part in the economic health of a country, as they, along with health care and education, absorb the largest amount of social expenditure in all countries (76-78).

While the importance of pensions to health is commonly accepted, the benefits of privatized versus public pension systems has become a widely contentious issue (77,78). By the 1980s, the financial viability of state-run pay-as-you-go[11] systems was being seriously questioned, and Latin American governments were encouraged by international financial institutions (IFIs) (most importantly the World Bank, the International Monetary Fund and the Inter-American Development Bank) to privatize their pension systems as an integral part of their SAPs (76,79-82). Theoretically, advocates argued that privatized pensions were

[11] In pay-as-you-go pension systems taxes collected from current workers are transferred to current retirees.

financially more viable because they were fully funded[12] and were therefore not as easily undermined by the aging of the population (80,83). Private systems were also argued to generate better rates of return than public systems, which meant they required lower payroll taxes (81). In addition, the privatization of pensions was supposed to cut administrative costs by providing competition among providers and reducing payment evasion by tying pensions more directly to contributions (81,84).

Private pension systems were further purported to reduce inequities found under the old system by being less vulnerable to manipulation for political purposes (81,82). On a macroeconomic level, privatization was also seen to be as a key tactic in addressing the devastating cutoffs of foreign capital and declining rates of domestic savings that plagued Latin America in the 1980s and 1990s (78,79,81,83). Neoliberal economists argued that pension privatization would increase national savings and thereby reduce dependence on unstable foreign capital, because the contributions that workers made to the privatized systems were saved, whereas in pay-as-you-go systems, the social security contributions of active workers were spent on the pensions of current retirees (83).

Critics of pension privatization argued against it based on both its financial and social implications. From an economic standpoint, privatization can create substantial funding deficits due to transitional costs and loss of tax revenue, and is unlikely to produce savings where the costs of transition are debt-financed, as the increase in private savings will be offset by a decrease in public savings (83,85). In addition, private systems are vulnerable to inflation, bankruptcy and fraud, and the state would almost certainly be obliged to cover some of its debts should a private institution run into financial problems (81).

[12] Fully funded systems collect taxes from workers when they are young, invests the proceeds on there behalf, and years later pay their benefits out of the accumulated principal and interest.

Along with economic uncertainties, privatizing social security has also been critiqued for its potential to undermine the social protection and public well being it was created to provide. The claimed efficiency of privatized firms is uncertain as they can lead to a concentration of ownership and as a result increase profits at the expense of pensioner returns on investments (78,86). Administrative costs in privatized systems have been found to increase substantially, reducing the size of funds available to retirees (85). Privatization has also been accused of being susceptible to abuses of rent-seeking[13] behavior further reducing efficiency gains supposedly garnered through increased competition (78,86). Retiree benefits in private systems can also be affected by demographic transitions; as large cohorts begin to retire and sell their asset returns on investments may decline (81).

At particular risk under a privatized system are the poor and most vulnerable populations (78,81,86). The working poor under a privatized system confront the prospect of having to pay contributions that they can't afford. Along with low wage employees, atypical employees (in part-time, casual or piece-rate employment) and intermittent employees (frequently women with children) are often neglected in privatized schemes. Redistributive mechanisms and coverage of marginal populations present in public social security plans are often ignored in private schemes. The privatization of social security, then, has the potential to lead to increased economic risks and to erode public mechanisms aimed at the protection of the most vulnerable sectors of society.

2.2.5 Health Care Systems

The effects of health system reform promoted by the World Bank and the IMF in LMICs are similarly contentious. Favouring a market-oriented approach to health sector

[13] Rent seeking takes place when an entity seeks to extract uncompensated value from others by manipulation of the economic environment -- often including regulations or other government decisions.

reform, structural adjustment conditionalities often mandated reduced fiscal spending on public health care, direct cost-recovery (user fees) and community-based financing, increased private provision and financing, and administrative decentralization (1,30,64). Advocates claimed that the marketization of health care would reduce costs and increase the efficiency, equity and sustainability of health systems (1). Critics countered that the alleged efficiency benefits of these health reforms are rarely realized and that profit-oriented health care leads to increasing health inequities and poorer overall health provision (30,87). User fees, a SAPS-imposed feature of public as well as private health care provision, had a disastrous impact by deterring the ill from seeking medical treatment and encouraging non-compliance with medications particularly among poorer populations.

In some cases, the burden of medical costs have also generated and deepened existing poverty (1,64). The for-profit nature of private health provision can further compound health inequities by giving preferential service to higher income groups and neglecting health concerns that affect the poor. Large pharmaceutical companies, for example, place a low priority on research and technological development for major killers in low income countries such as malaria, tuberculosis, and HIV/AIDS (30). For-profit health systems tend also to emphasize profitable interventions and disease specific treatments rather than focusing on preventative and integrated approaches that have long-term population benefits (1). Thus, market-oriented reforms can lead to the prioritization of economic benefit over that of the health needs of the population and especially of the poor (88).

Chapter 3 Methodology

This comparative historical analysis (CHA) incorporates a comprehensive framework and enlists a variety of data sources in order to trace and explore the complex ways SAPs affect health. In this Chapter the methods used to analyse the economic, social and health effects of SAPs on Argentina and Uruguay are described. The theoretical foundation for the use of CHA in the study is discussed as well as the utilization of the globalization and health framework to identify the countries selected, and the neoliberal reforms and outcomes to be analysed. Finally the Chapter examines the methodological limitations of the study and the data sources employed.

3.1 Comparative Historical Analysis

CHA is used to analyze relationships between different elements in the framework of globalization and health (See figure 1). CHA arose in the social sciences specifically to study complex social phenomena, such as globalization(89-91). Broadly speaking CHA was chosen because it is used to describe studies that juxtapose historical patterns across cases. More specifically the defining elements of CHA are its emphases on causality, processes over time and its use of systematic and contextualized comparison typically in a small number of cases(92,93). The following section will further explore what is meant by these terms and how they are manifested in my thesis research.

The first key element of CHA, causality, implies that the research undertaken is focused on identifying and explaining causal patterns that have widespread effects(89,93). The two main approaches used in CHA to infer causal relationships are process tracing and congruence testing. Process tracing involves using empirical observations within the cases

that support deductions about how events are linked over time. Process tracing is reflected in my thesis research through the analysis of the effects of neoliberal economic reforms that were a part of the standard SAP packages promoted in Latin America generally, and to varying degrees in both of the case study countries, on the 'pathways' inferred by the framework connecting globalization and health[14]. Causality in this study is not achieved through statistical analysis, but rather through an accumulation of evidence linked along the causal or path dependent chains of the globalization and health framework. The causal chain in this study begins with the macroeconomic conditionalities of SAPs that then 'cause' certain effects within the causal chain model. The second element used in CHA to infer causal relationship, congruence testing, uses cross-case comparison to prove or disprove common patterns found within the cases through process tracing. In my thesis research congruence testing occurs in the juxtaposition of two nation states Argentina and Uruguay. The within-country pathways analysis of the phenomena of structural adjustment programs is used to make between country comparisons that provide a further dimension in understanding of the effects of SAPs on health in the countries.

The second element central to CHA is its concern with looking at processes over time(89,94). Events studied in CHA are not considered to be static but rather fluid processes manifested over time. In my thesis research temporal considerations are central to the exploration of the effects of SAPs. The study period of the early 1980s to the year 2000 tracks the implementation of SAPs and their effects within the countries as they unfold over the two decades. The sequence and duration of structural adjustment conditionalities and

[14] Hereafter references to SAPs includes both reforms that may have specifically been mandated as loan conditionalities and those otherwise adopted 'voluntarily by the countries, though arguably due to the influence of SAPs.

their multifaceted effects are considered, as well as a comprehensive analysis of the historical events precipitating their implementation.

The third element central to CHA is its use of systematic and contextualized comparison (92). This approach allows the researcher to explore and contrast the theory against the evidence in a way that is not as easily achieved through quantitative social research. In my research this technique allows for a dialogue between the abstract theory of Saps and its empirical historical effects within a concrete country setting. Through CHA and the globalization and health frameworks, the complex effects of SAPs from macro to micro level are considered in a manner that incorporates socio-economic, political and historical contexts.

3.2 Choosing Latin America

The first stage of research was equivalent to the sample selection phase in any standard research project. In choosing the countries for this study, there were a large number of potential pairs that could have been selected. Due to the impracticality of exploring all of these possibilities, the initial phase of the selection used a crude process to narrow down the prospective cases. Of the potential regions where SAPs were implemented, Latin America was chosen. Latin America has several advantages as a research area. First, it is an area of the world that I had more familiarity with since I had worked and studied in Central America for almost a year. This familiarity gave me the advantage of having some understanding of the history, current issues and the culture of the area that would be lacking in other parts of the world. Latin America also has many practical research advantages as its economic development level ranges from lower middle to upper middle-income countries (with the exception of Nicaragua, which is a low-income, least developed country) (95). Choosing countries from a middle-income level of development allows differences in health outcomes

due to SAPs to be more easily noticed than in regions (e.g. Sub Saharan Africa) that are made up of predominantly low-income countries where potential differences might be negated by the severe poverty present. In addition a middle-income region has more probability of having reliable and accessible data than a poorer region (4). Finally Latin America is also the region of the world where the greatest inequalities are found and where, on average since the 1980s, income inequality has tended to worsen(13,96,97). According to the World Bank in 2004 the richest 10 percent of the population of Latin America and the Caribbean earn 40 - 47 percent of total income, while the poorest tenth earn only 2-4 percent(96). As SAPs are often critiqued for increasing income inequality, the high and worsening levels of inequality in Latin America make this region an important area to be studied.

3.3 Selecting Argentina and Uruguay: Matched Characteristics

The second layer of the selection process, choosing the countries, employed a more refined set of criteria. The first set of criteria were developed through a process of matching that serves a purpose similar to controlling for confounding in any standard research project. Matching the countries on factors that were present before SAPs were introduced (from the category pre-existing endowments in the globalization and health framework) allows for the differences being observed after SAPs were implemented to be credited to differences in the way SAPs were adopted rather than being attributed to other unrelated factors (e.g. economic development levels prior to the on set of SAPs). While theoretically matching does control for confounding, the vast and complex factors (e.g. geographical, cultural, political, economic) that are entailed in matching countries makes the selection of measures and the ability to control for differences a difficult task. Rather than trying to undertake an impossible goal of methodologically controlling for all differences, the research task was

more usefully aimed at developing a reasonable, and reasonably consistent set of criteria made up of key factors known to determine health. The characteristics on which the countries were matched represent key similarities (economic development level, SAPs date of implementation, historical political and economic development) and differences (social structures and domestic policies and inequality levels) in factors recognized to be important determinants of health. The following is a description of the similarities in the health determining characteristics in Argentina and Uruguay before SAPs were implemented.

3.3.1 Upper Middle Income Countries

The first criterion used in the selection of the countries from Latin America was their economic levels as categorized by the World Bank prior to the on set of SAPs. The countries were chosen from similar economic levels in order to reduce the chance that their differing financial situations would be responsible for the differences in health outcomes noted at the end of the study period (2000). The countries finally chosen, Argentina and Uruguay, were both categorized as upper middle-income countries prior to having taken on SAPs (95). As the range of GNP levels that make up this category are quite broad, and GNP does not capture the complexity of a countries development level, this criterion only allows for an initially crude narrowing of country choices. The selection was further refined by considering GNP in conjunction with other more sensitive measures (e.g. timing of reforms, historical trajectory) described below.

3.3.2 Time in which SAPs were Implemented

Having both countries implement SAPs at comparable times provides a better chance that their impacts will have had an equal opportunity to become observable in the health data. This measure recognizes that the impacts of economic interventions like SAPs are often delayed and require time to manifest themselves. This criterion also ensures that

the countries were facing similar external conditions during the time period in which they were both adopting SAPs. Chile, for instance, in the aftermath of the overthrow of Allende[15], adopted SAPs voluntarily more than a decade earlier than most other Latin American countries (34,42). Comparing the impacts of SAPs on health in Chile to another country that adopted SAPs during the 1980s would leave the possibility that observed differences could be due to the political, economic, or technological differences between the two decades. In the selected countries Argentina and Uruguay, difficulties in debt repayment and government revenue had periodically been encountered before the 1970s and as a result both countries had had limited conditionalities imposed by the IMF over this decade. The debt crisis and the resulting onset of structural adjustment programs in the 1980s marked a drastic increase in the intensity of the reforms that were required of both countries by the IMF and the World Bank. The selection of Argentina and Uruguay for the case study reduces many of the possible biases that differing time periods could introduce into the interpretation of the health outcomes of the countries.

3.3.3 Economic Development History

Another important similarity shared by Argentina and Uruguay was the historical development of the economy of the countries. Argentina and Uruguay share economic roots that were based on the exportation of primary products abroad and the importation of manufactured goods(44,98). During the late 19th and early 20th centuries the economies of the two countries began to excel based on the export of cattle, sheep and grain products to England. Argentina especially experienced rapid economic growth due to its abundant natural resources. While this period was generally prosperous, dependence on demand and

[15] Salvador Allende (1970-1973) was the social democratic president of Chile ousted in 1973 with support from the CIA to prevent what the US perceived as another 'socialist' foothold in Latin America.

foreign capital from industrialized countries caused the economy to fluctuate. Their vulnerability to the world market became acutely apparent in the 1930s when the world depression caused an economic crisis in both countries.

In reaction to the depression of the 1930s, Uruguay and Argentina along with other Latin American countries introduced ISI policies(43). As already discussed, these policies encouraged inner-directed development through strong government intervention; the intent was to produce manufactured goods internally that formerly had been imported from Europe. In Argentina in 1930 domestic manufactures provided less than 9 percent of Argentina's total consumption of textiles, but by 1943 their share rose to 82 percent(44). ISI policies were initially successful in generating economic growth and improving social conditions but economic problems began to surface in both countries by the mid 1950s and early 60s(4,49). ISI policies had not broken dependence on developed world economies since the policies relied upon imported capital goods such as machinery (4). The funding of capital goods through loans led to a growing trade deficit as returns on investments were lower than the interest rates being charged on loans. Over-valued exchange rates exacerbated the problem since these firms could not find external markets for their high priced goods. Though ISI was leading to better socio-economic status for these countries, it was simultaneously spiralling them into greater debt (43).

The 1970s marked yet another transition in Argentina's and Uruguay's economic policy. In 1973 in Uruguay and in 1975 in Argentina the military took power (43,44,98). During the military rule in the countries the inward looking import substitution model was replaced with an export-led model of economic growth. This model had many similarities to neoliberal economic theory in that it advocated the deregulation of finance and trade and a reduced role of the state in the economy. Economic growth during this period relied on

external borrowing to finance expansion of the export sector of the economy, which in turn led to an increasing foreign debt. The foreign debt burden of the countries was exacerbated by quadrupling oil prices and rising interest rates that finally culminated in the debt crisis of the early 1980's(43,44,98). Uruguay's foreign debt went from $515 million in 1976 to $2.26 billion by April 1981 and Argentina's foreign debt had reached $43 billion[16] by the end of 1982(98). In 1982 Argentina and Uruguay negotiated emergency loans and entered into structural reforms with the IMF (44).

3.3.3 Racial and Ethnic Composition

A further similarity between the countries was the development of the racial and ethnic composition of the countries. Uruguay and Argentina are countries of primarily European ancestry (44,98). Both countries were colonized by Spain in the 1500s and during the economic boom of the late 1800's and early 1900's massive amounts of immigrants from Spain and Italy came to fill the demand for labour. Today more than 90 percent of Argentineans and Uruguayans are said to be of Spanish or Italian heritage. Unlike other Latin American countries, there are few people of indigenous heritage left in either country.

3.4 Argentina and Uruguay: Key Differences

In addition to matching countries on health determining characteristics before SAPs were implemented, key differences between the countries were used in the selection of the cases. An important aspect of the study is its focus on domestic policies and their ability to mitigate the negative health impacts of SAPs. In choosing two countries for the study, differences in the historical development of their domestic policies before SAPs was used as a good predictor of possible differences in the way the countries might implement the adjustment policies. As a common critique of SAPs is the negative impact it has on the social

[16] All monetary figures, unless otherwise stated, are in US dollars.

well being of countries, a country's historical emphasis (or lack thereof) on policies that protect the social interests of its citizens was seen as an important factor to be considered. Countries that put a greater importance on social issues in their domestic policies were hypothesized as being more likely to retain this emphasis after SAPs were introduced than would be countries without this historical foundation. The following is a brief contrast and comparison of the differences and similarities in the development of Argentina and Uruguay's domestic policies and social structures.

3.4.1 Social Structures and Domestic Policies

Uruguay and Argentina's domestic policies and social structures share many similar origins but they have also emerged as modern states with important differences. Both countries share similar roots as colonies of Spain in the 1500s (44,98). As in other Latin American countries the colonial economy created a system in which the white ruling class dominated first Indian labour, then cattle and land. Demand for manufactured goods that the local economy remained unable to produce also gave a monopoly power to merchants who supplied these goods from abroad and to the urban areas that developed to supply these imports.

In the modern state of Uruguay and Argentina many of these legacies of colonialism remain. In both countries the majority of land is still owned by a wealthy minority, economic growth is still connected to foreign capital and markets, and both countries are largely urban countries dominated by their capital cities: Montevideo and Buenos Aires, respectively (43,44,98). Despite these similarities Uruguay's and Argentina's social development began to diverge in important ways in the 1800's at which time Uruguay progressed in a more equitable and stable direction than its more conservative and politically unstable neighbour Argentina.

3.4.1.1 Uruguay

Uruguay has often been characterized as the Switzerland of South America (98). It is a remarkable Latin American country in that relative to most other countries it has historically had a stable democracy, high literacy rate, large urban middle class, and relatively even income distribution. The uniquely peaceful and socially minded nature of Uruguay's modern state began to take shape in the late 19th and early 20th century. By the late 1800s Uruguay was economically prosperous and had developed relative stability, a secular government and an advanced public educational system. These progressive elements in Uruguay's development were followed by a welfare state that emerged under the presidency of Jose Batlle Y Ordonez (1903-07 and 1911-15). Batlle instituted a democratic welfare-oriented polity based on a vision of centralization and redistribution, which resulted in old age pensions, worker protections, state monopoly of finance and other sectors, and public assistance for women, children and the poor. Aside from a brief relatively peaceful breakdown in constitutional rule from 1933 to 1938 Uruguay maintained a stable democratic government that continued to follow the social vision of Batlle into the 1960s.

In sharp contrast to the traditionally equitable and peaceful development of the country, Uruguay over the 1960s and 70s descended into a military dictatorship that eroded its social policy, and dramatically increased violence and inequities in the country (98). The dictatorship of 1973 to 1985 operated under a doctrine of national security that saw its purpose in eradicating socialist institutions and policies created under the Batllista welfare state. One of the central aims of the military became the destruction of the labour movement and the cleansing of leftist influences in the social, educational, and moral

structures of society. During the dictatorship there were approximately 90 deaths and 44 disappearances and it is estimated that 10 percent of Uruguay's population fled the country. In 1985 the end of the military regime left a deteriorated infrastructure, an impoverished middle class and a legacy of human rights violations.

3.4.1.2 Argentina

In contrast to Uruguay's early adoption of social policy, Argentina's development was heavily influenced by the political agenda of wealthy landowners who controlled both the army and the elections (43,44). Argentina experienced significant economic growth that facilitated some upward mobility at the end of the 19th and beginning of the 20th centuries; the political and economic dominance of aristocrats, however, resulted in huge income disparities. Tensions between the working class and the elite led to protests and strikes by labour that were violently suppressed. In 1930 a military coup took place and from 1930 on democratic government was interrupted by frequent military coups. Between the military coup of 1930 and 1976 only one freely elected government managed to complete its term.

Although Argentina was more dominated by an aristocracy aligned with the military, it also experienced an important period in which popular government prevailed(43,44). Over the 1930s and 1940s, while the military maintained a growing influence over the political system, class-consciousness was growing. Juan Peron, a middle class army Colonel, campaigned for the presidency from a nationalist and populist platform; in 1946 he was elected president and was re-elected again in 1951. From 1946 – 55 Peron, before he was ousted by the military, implemented dramatic social reforms that improved employment conditions, education and health care for workers. During this period Argentina developed the largest middle class on the continent and established a powerful union organization, the General Confederation of Labour.

Over the two decades following Peron's departure Argentina again descended into political turmoil that culminated in an extremely violent and repressive military dictatorship in the 1970s (43,44). After the military took power in 1956 social and political divisions between the left and the right grew increasingly tense and volatile. A severe stabalization plan was implemented that increased income inequalities in the country. Another military coup took place in 1966 that was only broken by a brief period of democracy from 1973-1976. From 1976-83 the military engaged in a "dirty war" against their opponents in which massive arrests and the disappearances of anywhere from 10 to 20 thousand people took place. In addition to the brutal internal war, in 1982 the Argentine government invaded the Falkland Islands but was quickly defeated by the British. Following their defeat the Argentine military government faced increasing public resistance along with worsening economic conditions that eventually led to the return of a civilian government in 1983.

In summary, Argentina and Uruguay's history demonstrated significant differences in their democratic stability, tradition of social policies and history of violence. Uruguay adopted strong social democratic policies in the early 1900s that were largely maintained until the military take over in the 1970s (98). In contrast Argentina was dominated by upper class interests in the early 1900s and only implemented social democratic policies during the presidency of Peron in 1946-1955 which were aggressively reversed under the military regimes that followed (43,44). Uruguay's history was also largely peaceful and democratic only interrupted by a brief and relatively peaceful military takeover in the 1930s and the more violent dictatorship in the 1970s (98). The 1900s in Argentina, in contrast, were riddled with violence and unrest with frequent military coups that culminated in a brutal military takeover in the 1970s (43,44). Argentina's history was to a large degree characterized by greater inequity, violence and military intervention that differed substantially from Uruguay's

generally more peaceful, democratic and social democratic progression, likely resulting in significant differences in the way SAPs were adopted by and affected the countries (43,44,98).

3.4.2 Inequality Data

Along with the differences in the historical development of the domestic policies and social structures of the countries before SAPs were introduced, differences in the progression of income inequality in the countries after SAPs were implemented was another key factor in the choice of the countries. At the beginning of the 1980s Argentina and Uruguay both had similar levels of income inequality; by the end of the 1990's Uruguay's inequality improved while Argentina's worsened. Data from the Economic Commission for Latin America and the Caribbean (ECLAC) show that the percentage of income in the poorest quartile in Argentina went from 9.3 in 1980 to 7.5 in 1997, and in Uruguay from 9.3 in 1981 to 11.9 in 1997(99). As increasing inequalities is a common critique of SAPs, Uruguay's improving and Argentina's worsening equality point to possible differences in their domestic policies and their ability to buffer the negative impacts of SAPs. The differing inequality data along with the differing historical emphasis on social policies provides further evidence that a comparison of Argentina and Uruguay's domestic policies may provide important insights into how to preserve social and health interests of the public in the face of neoliberal economic policies.

3.5 Population Health Analysis: Health Determinants and Outcomes

In this section, a discussion is given of the specific population health determinants and outcomes that will be used to measure the cumulative population health effects of the neoliberal reforms outlined in Chapter 1. The health determinants chosen include economic growth, inflation, debt, inequality, poverty, and the health outcomes are infant mortality rate

(IMR) and under five mortality rate (IMR). These indicators were chosen because they create a comprehensive picture of population health in the countries through an examination of broad economic and social determinants and because of their corresponding relationship to the health outcomes. Economic growth, inflation and debt affect and are reciprocally affected by poverty and inequality which, in turn, are strongly linked to infant and under 5 mortality. A collective exploration of these complex and interrelated health determinants and health outcomes provides a representative depiction of the overall population health of the countries and validates and strengthens the interpretation of the health outcomes. What follows is a discussion of the importance of the chosen indicators to health and their connection to the other health determinants.

3.5.1 Economic Growth

Looking at the economic effects of neoliberal reforms is imperative since the economy functions as an important health determinant (100). A country's economic activity, its place in the international economy and the approach taken by its government to issues as diverse as economic development, trade and taxation all affect the socio-economic conditions and consequently health status and distribution within a country (55). How economic health is measured and the importance it is given, though, continues to be controversial. From a neoliberal economic viewpoint an emphasis on economic growth measured as Gross Domestic Product (GDP) emerged as a central aspect of not only economic development but also social well-being through growth's presumed alleviation of poverty and inequality(36,101). Chen and Berlinguer have noted that advocates of growth argue that " a rising tide of wealth lifts all boats, leading to health advancement and equity" (30). On the other hand, this narrow focus on aggregate economic growth has been critiqued because it does not take into account the need for redistributive mechanisms, public

investment, and environmental protection. Under this alternative rationale "a rising tide could lift big yachts, but capsize small dinghies" (30). Problems with GDP as an economic indicator of well-being have also arisen as it captures both destructive and beneficial causes of growth in goods and services and is not able to take into account activity in the informal economy(102). While GDP is a controversial and limited measure of economic well-being it is still an important aspect to examine as it was a central goal of neoliberal reforms in the countries examined (4). Judging the effects of SAPs' reforms, then, requires assessing whether at the very least they achieved their own aspirations. Use of GDP as one among several economic, social and health indicators also allows a more comprehensive understanding of the effects of these neoliberal policies on the countries.

3.5.2 Inflation

Inflation is another important economic outcome because economic stability (which is undermined by high inflation) was a central goal of neoliberal austerity measures and plays a significant role in the economic performance and consequent economic health of a country (67,103). Inflation is the persistent rise over time in the average price of goods and services or in what is often referred to as "the cost of living". The most widely used measure of inflation is the consumer price index (CPI)(104). It reflects changes in the price of a representative "basket" of goods and services sold in the country. The inflation rate is expressed as a percentage increase in average prices over a year. When the CPI rises the purchasing power of the average consumer falls.

The cost of high and unstable inflation can be severe as it undermines the economy's ability to generate long-lasting growth and job creation (104). It also creates uncertainty for consumers and investors and can lead to painful cycles of economic "boom and bust" that cause hardship for many people (104). Inflation debilitates a country's ability to provide

public social services because tax revenues fall and economic uncertainties hinder budgetary planning (67). This often leads to an erosion in essential services that affect the most vulnerable sectors of society. In addition high inflation erodes the value of incomes and savings. People on fixed incomes, the elderly and the poor, are particularly vulnerable to inflation (104,105). Low wage earners and the less educated, for instance, are less likely to have the bargaining power to be able to have their wages adjusted for inflation (67,106). Inflation also taxes the poor more heavily because they hold proportionately more of their money in cash and are less able to protect their wealth through domestic indexed or foreign-denominated financial instruments (67).

3.5.3 Debt

Another key measure of economic performance relative to neoliberal reforms is the development of debt(49,107). Repayment of developing world debts was a central reason for implementing neoliberal reforms; a country's debt burden also has serious implications for the health of its people (4,107,108). The effects of debt on the economic systems of a country and consequently on its health outcomes are complex and include many factors. The most obvious implication of debt has been the significant and increasing outflow of capital to industrialized countries that were the principle lenders to finance the external debt (109). According to the World Bank: "Before 1982 the highly indebted countries received about 2 percent of GNP a year in resources from abroad; since then they have transferred roughly 3 percent of GNP a year in the opposite direction" (109). The problem became so pervasive that even agencies whose ostensible purposes included aiding the indebted countries were draining capital: in 1987 "the IMF received about $8.6 billion more in loan repayments and interest charges than it lent out" (109). Most of the increase in the foreign debts of developing countries during the 1990s was to pay interest on existing loans (55). In six of the

eight years from 1990 to 1997, developing countries paid out more in debt service than they received in new loans – a net transfer from the 'poor South' to the 'rich North' of $77 billion (55). In addition to the moral affront of this reality it is also counter intuitive to set up a system in which developing countries attempting to recover and reconstruct themselves after the debt crisis are paying out more to service foreign debts than they will ever receive in emergency aid (110).

Generating funds for debt repayment has had significant implications for indebted countries. In order to generate money to pay debts expenditure reducing policies have been undertaken to cut public expenditure. Socially this has directly affected countries through the reduction of spending on social safety nets and infrastructure which often most negatively affect the poor. Not only did these expenditure reductions have harmful social consequences on people in affected countries; they also had serious consequences for the prospects of renewed growth as decreasing investment inhibited productivity (111). In addition countries often had to take on new loans to pay off old loans(43). In this way the debt crisis has had a self-reinforcing dynamic that has continued to increase the debt burden and accentuate the mounting human costs.

3.5.4 Poverty

Research on the relationship between poverty and health has left little doubt that poverty leads to ill health (112,113). The effects of poverty on the health of individuals can be ascribed to both its social consequences in feelings of risk, powerlessness, vulnerability, and low self-esteem, as well as to the absolute effect of material deprivation (56). People with limited access to income are more likely to be socially isolated, have fewer opportunities for early childhood development and later education, and have poor access to drinking water, health care services and housing. In addition, poor people are more likely to suffer

from environmental degradation, discrimination, have a larger number of children, unwanted pregnancies and be more vulnerable to addictions (114). An examination of the demographic breakdown of poverty reveals that gender, age and race are also key factors in understanding poverty (115). Women, the elderly, children and non-white ethnic groups make up a disproportionate number of those living in poverty and are often more susceptible to experiencing the negative effects of economic crisis (9,67,96,115).

Examining poverty is important but difficult due to the inescapable degree of arbitrariness in the establishment of poverty lines that could have a great impact on the number of people who are defined as poor (116). In low-income countries a large part of the population is likely to have incomes close to the poverty line and so a small variation in the definition of that line could significantly affect the numbers reported. Poverty also typically has been thought of in terms of access to resources, but alternative measures have been developed that include economic, structural, socio-cultural and geographic elements (117). Even with traditional poverty measures that focus on income, the income measures on which they are based can vary widely. Some countries report only labour earnings, for example, while others report both earned and nonearned income (67). The variety of definitions and measurements of poverty can make it difficult to achieve comparability across countries and over time. For the sake of this study a comprehensive analysis of the poverty measures available for Argentina and Uruguay is not possible. Instead a summary of the literature on aggregate poverty measures for the countries is presented with an example of poverty using the measure from ECLAC. ECLAC is used because it provides a consistently measured indicator over the 20 year time period for both countries, facilitating an easier and more reliable comparison of the two countries.

3.5.5 Inequality

While poverty is an important outcome to be measured, it fails to capture the affects of neoliberal reforms on income distribution at all levels of society. Increasingly not only poverty but the degree of inequality that exists in countries is being recognized as an important determinant of health(118). Ironically, from a neoliberal perspective it was initially argued that focusing on changing the incidence of poverty is more important than worrying about altering income distribution (119,120). Economic growth was thought to be the solution to poverty alleviation and stressing income redistribution would slow investment and growth and therefore negatively affect the poor (120). This argument has some historical merit since, for example, Latin American countries through the 1960s seemed to be on their way to eradicating poverty through growth without redistributing wealth (121). However the theory that growth automatically reduces poverty has been generally refuted by repeated examples of countries who simultaneously experienced increased poverty and growth (36,120).

The neoliberal emphasis on poverty reduction over inequality reduction also neglects to consider that well-being can depend on relative as well as absolute poverty (121). To start with, inequalities have powerful but subtle psychological implications that have positive and negative consequences for health. Social status, for instance, is strongly connected to a sense of personal efficacy. In general, higher social position is associated with a greater belief in one's ability to positively affect life circumstances and lower social status with a sense of powerlessness and lack of control (122). Moreover, the experience of poverty can also be worse in a society with greater inequities. The presence of wealth in society, for example, encourages merchants to sell more expensive products that are more profitable lessening the ability of lower income people to access goods that meet their basic needs at affordable prices (119).

Inequality is affected not only by the economic, political and social contexts but has a reciprocal effect on these contexts. Countries with more equal income distribution, for example, tend to have higher growth rates and greater democratic stability (67,119). Additionally, income inequality also can contribute to and perpetuate poverty. Latin American poverty, for example, has often been called "unnecessary poverty" as very little poverty would exist if incomes were more evenly distributed (121). Addressing inequities, then, is an important aspect of achieving health on its own and is also interconnected with poverty, economic growth and stability that collectively have a significant impact on health (96).

3.5.6 Infant Mortality and Under Five Mortality

Two bellwether health measures are under 5 mortality (<5 MR) and infant mortality rates (IMR). These were used to measure the effects of neoliberal policies on the health of Argentina and Uruguay. These measures were chosen both because of their ability to provide a reliable indication of the overall well-being of countries, and because of the lack of other reliable comparable data. Research for over the last 100 years has used IMR as an indirect overall indicator of economic, social and environmental development in countries because of its sensitivity to changes in economic and social conditions (123). The correlation between IMR and these variables historically has been so consistent and close that they have been viewed as either directly or indirectly causative .

IMR and <5MR are caused by many complex variables but its most notable and commonly accepted determinant is poverty. Low economic status is generally related to IMR and <5MR because of its association with risk factors such as lack of education, sanitation, clean water and nutrition (124). Income inequality also has been found to be strongly

associated with these indicators, because of its negative impacts on social cohesion and its association with decreased state spending on health care (125,126).

While it is generally accepted that childhood and infant health are important reflections of health throughout life and that infant and children's health is a sensitive measure of a countries progress, the use of IMR and <5MR as an accurate measure of infant and childhood health and as a surrogate measure of the overall health of a country has become controversial. Even though this indicator has been useful in the past, its interpretation today has become less reliable as it has become possible to alter the number of deaths of children below one year old as a direct result of the application of specific techniques that do not require economic and social improvements (123). The encouragement of breast feeding, the use of oral rehydration, and immunization against infectious diseases, for instance, can reduce the IMR without changing the prevalence of illnesses, disabilities or the extent of human deprivation that exists.

While the limitations of these indicators are important to recognize as they could falsely mask or amplify the progress in health of a country, undertaking a comparative case study reduces some of these concerns. As Argentina and Uruguay both come from similar economic development levels and have had long established social and health systems, targeted health interventions would likely be equally available to both countries eliminating them as possible causes for differences in mortality rates(95). In addition even if the difference in IMR and <5MR were due to the presence of targeted interventions in one of the countries, this could to some degree reflect the different implementation of neoliberal reforms within the countries. In Argentina, for instance, as will be elaborated on in Chapter 4, problems with inflation and the implementation of fiscal austerity in the 1980s had a

significant impact on the ability of the health system to operate effectively and put their immunization program in serious jeopardy (127).

3.6 Methodological Challenges

The complexity of factors involved in undertaking a country case comparison raises many unique and distinct challenges. A key example of this complexity is the use of matching to control for confounding in the study. While matching allows for controlling of confounding by the factors that the countries have been matched on, the diverse and complex nature of a country will inevitably result in unaccounted for differences between the countries that will need to be considered in the study analysis. Differences between the countries in factors other than the way they adopted SAPs could lead to a misinterpretation of the country's successes or failures in implementing SAPs.

In addition to the inherent difficulty in matching countries on their health determining factors, using countries as cases raises possible concerns about their level of interdependence. In the context of an increasingly globalized modern world, it is important to recognize the growing interdependence that countries are experiencing. In looking at health issues, environmental pollution, economic crisis and infectious diseases are all examples of factors that transcend the borders of the countries in which they originate. In looking more specifically at Argentina and Uruguay their close geographical position and historical ties intensify the possibility of the internal issues and events of one country affecting the choices and circumstances of the other. Taking into account the impact that the countries have on each other is a necessary piece of the analysis, as the more interdependent the countries are, the greater are the chances that any possible differences in health outcomes will be diminished.

3.6.1 Size/Population/Terrain/Climate

Argentina and Uruguay have important similarities and differences that make them good choices for a comparative case study, but there remain obvious differences between the countries that could interfere with the accuracy of the study. One of the most easily observable differences between Argentina and Uruguay is size. Uruguay is the smallest country in South America with a land area covering approximately 72,000 square miles while Argentina is the second largest country in South America covering 1,056,636 square miles (44,98). Argentina's population of 39,537,943 is also significantly larger than Uruguay's population of 3,415,920. Along with the dramatic differences in size and population the countries also have very different terrain. Argentina's territory is richly diverse possessing mountains, plains, forests and beaches while Uruguay's largely level, open landscape shares the flatness of the Argentinean pampas but not the richness of its soil. Uruguay is almost totally bordered by water and its land is made up of mostly grasslands, 90 percent of which are capable of growing crops. Even though Uruguay lies next to Argentina, Argentina's long triangular shape stretches north almost to the tropic of Capricorn and south to Antarctica making its weather much more diverse than Uruguay's generally temperate climate. Temperatures in Argentina vary from subtropical in the north to cold and windswept in the south, with mild and dry areas found throughout much of the country. Argentina's greater size, population, diverse climate and terrain create significant differences in the possible health issues that it could encounter in comparison to Uruguay's smaller more uniform land and climate. Argentina, for instance, may experience problems in health care delivery and other services in less accessible and remote regions, and may face more diverse health problems due to differences in climate that may not be an issue in a smaller more homogeneous country like Uruguay. These differences may complicate the interpretation of

the study by giving a false impression of worsening health outcomes in Argentina that may be due to its greater size and diversity rather than to differences in its domestic policies.

3.6.2 Foreign Relations

While there are many advantages in choosing country cases with similar characteristics like Argentina and Uruguay their close proximity, cultural and political ties can also jeopardize their independence and reduce the ability of the study to find a difference in their health outcomes. Uruguay and Argentina's development has been historically interconnected though their effect on each other has not been equal due to Argentina's greater size and power (44,98). Uruguay's early development was shaped by conflict between Spain/Argentina and Portugal/Brazil over possession of its territory and it has remained a fragile buffer between the South America's two major powers of Argentina and Brazil (98). In many ways Uruguay has maintained a remarkably unique and distinct character that has resisted the more violent and conflict-ridden path taken by its neighbors. But, despite its independent development, pressures from Argentina have influenced the domestic affairs of Uruguay. A key example of this influence is the authoritarian regime in Argentina in the 1960s which supported the military government that came to power in Uruguay. Uruguay's vulnerability to the external pressures of Argentina undermines the independence of the two country cases and weakens the ability of the study to find differences in their adoption of SAPs and resulting health outcomes.

Another factor that jeopardizes the independence of Uruguay and Argentina as case studies is their economic ties to each other. Bilateral trade agreements that arose in the mid seventies tied much of Uruguay's exports to Argentina and Brazil and the development of the regional trade agreement Mercosur in the 1990s continued to deepen Uruguay's dependence on this market (128,129). Uruguay is also dependent on Argentina for foreign

investment. In 1980 and 1981 for instance the financial crisis in Argentina further added to the economic problems of Uruguay by virtually eliminating the real estate investment from Argentina; a major source of foreign investment for Uruguay (98). As Uruguay's markets are very small in comparison to Argentina fluctuations in Uruguay's economy have only a very minimal reciprocal effect on Argentina. In comparing the impact of SAPs on Uruguay and Argentina the susceptibility of Uruguay to fluctuations in Argentina's economy could reduce the ability of the study to find a difference in their resulting health outcomes.

Chapter 4: Focusing On Selected Reforms

The following Chapter explores the neoliberal reforms adopted in Argentina and Uruguay over the 1980s and 1990s, the most critical period in which SAPs were implemented. This Chapter builds a representative picture of the neoliberal reforms to domestic policies undergone during the implementation of SAPs in these two countries, using a sample of social, economic and health policy areas. These policy areas include trade, privatization, labour market, pension and health care, the health-rationale for each having been explored in the first Chapter. The analysis compares and contrasts the differences in the pace, intensity, and comprehensiveness of the reforms adopted and explores the effects of these changes on the reformed sector.

4.1 Trade Reforms

4.1.1 Argentina's Trade Reforms in the 1980s: Deterring imports, reducing tariffs and quantitative controls

In the latter part of the 1980s a moderate form of trade liberalization was initiated in Argentina under the newly elected democratic government led by President Raul Alfonsin (1983-1989) after a failed attempt under the previous military regime (41,44). The main goal of trade reform in this period was focused on generating a large trade-surplus in order to appease IFIs, private banks and the US who were pressuring Argentina to make prompt payments on the rapidly increasing debt (41,130). As the economic problems of the 1980s made the prospect of increasing exports through new foreign investment unlikely, much of the trade surpluses had to be attained by curtailing imports through IMF-supported austerity measures (41). Domestic demand for imported goods was suppressed by reducing government spending, raising taxes and increasing interest rates (44,116).

While Argentina deterred the demand for imports to develop a trade surplus to pay its debt, SAPs also advocated for reduced barriers to imports in order to decrease the price of inputs necessary for exportation (130). With this goal in mind Argentina dismantled quantitative controls and tariff distortions (130,131). Nominal import tariffs were reduced from an average of 45 percent in 1987 to 29 percent at the end of 1988 (129,129,132). In addition non-tariff measures were reduced through the elimination of specific duties and quantitative restrictions[17] (129,131,133).

Greater exports were also advocated under SAPs in order to increase foreign currency. Export tariffs were reduced to encourage exportation from 1986 to 1988 but were increased in 1983, 1985 and 1989 for fiscal reasons. From 1985 to 1988 basic export incentives such as tax rebates and new incentives in the form of subsidies related to export performance were implemented to further promote exportation (133,134). Along with unilateral trade liberalization, bilateral trade liberalization was increased moderately over the 1980s. Trade was intensified through 24 bilateral trade agreements with Brazil negotiated between 1984 and 1990 (133,135). Between 1986 and 1994 Brazil became Argentina's main trading partner, and the share of Argentina's exports directed to Brazil grew from 6 percent in the mid-1980s to over 20 per cent in the mid-1990s (133).

4.1.2 Trade Reform Effects in Argentina in the 1980s: Trade surpluses and export diversification

An examination of trade liberalization over the 1980s reveals that it had both positive and negative impacts on Argentina's economy. One of the key successes that Argentina experienced was strong positive trade balances, which peaked at $8.3 billion in

[17] A quantitative restriction puts a numerical limit on the annual import quantity of a given good.

1990 (136). Recession and hyperinflation severely reduced imports after 1987, but exports expanded sharply--led in part by the successful export efforts of Argentina's steel and petroleum industries (137). Exports were also diversified; by 1990 industrial exports had increased to almost equal the level of the traditional agricultural exports.

While trade liberalization in the 1980s succeeded in producing a trade surplus and increasing the participation of industry in export markets, these benefits were accompanied by poor trade growth, the erosion of manufacturing sectors and in particular the devastation of small and medium sized firms. Despite the trade surplus achieved between 1983 and 1990 overall export growth remained poor with Argentina achieving 6.7 percent growth per annum, well below the 10.1 percent annual growth rate recorded by world exports (138). A closer look at the effect on industry also reveals that the bulk of exports were represented by a small number of sectors dominated by a few multinational firms. The vast majority of Argentine producers participated little in the international market and many smaller firms disappeared while large conglomerates expanded (137). The chronic inflation in the 1980s additionally forced industries to focus on self-preservation instead of investing in modernization.

4.1.3 Argentina's Trade Reforms in the 1990s: Accelerated unilateral and regional liberalization

In the 1990s the rate of unilateral and regional trade liberalization accelerated dramatically with the election of President Menem (1989- 1999). Faced with hyperinflation and spiralling debt, macroeconomic stability, increased investment and a sustainable process of high growth became the goals of adjustment in Argentina during Menem's term (130). In this context a more extreme approach to trade liberalization was initiated with the intention of reorienting investment toward tradable activities in order to earn the foreign currencies

Argentina needed (130,133,139). Unilateral trade liberalization advanced rapidly in the first term of Menem's administration. In 1991, the remaining quantitative restrictions on imports were eliminated and the average nominal import tariff was lowered from 29 percent in 1988 to around 13 percent in 1994 (129,130). Tariffs on exports were also eliminated after 1990 and a number of export promotion mechanisms were introduced, including a tax rebate for exporters which was raised to as much as 20 percent (130,133).

From 1995 onwards, trade policies in Argentina were further radically advanced through its integration into the regional trade agreement, Mercosur. This regional trade liberalization process began with the treaty of Asuncion signed in 1991 between Brazil, Paraguay and Uruguay with the goals of achieving the free circulation of goods, services and productive factors among the member countries through the elimination of tariff and non-tariff restrictions. The process of tariff elimination was progressively implemented until it reached a zero tariff state by the end of 1994, with temporary exceptions made for a limited number of products and the sugar and automotive sectors that were to be integrated into Mercosur by 1999. Mercosur also established the adoption of a Common External Tariff (CET) and a common commercial policy with non-Mercosur countries that was adopted in 1995. Except for temporary exceptions granted to certain imports scheduled to be integrated into CET by 2001, the average CET tariff was fixed at approximately 11 percent although tariff levels were allowed to vary between 0 and 20 percent across industries (129). Through unilateral trade liberalization and Mercosur, Menem's government succeeded in significantly advancing the assimilation of Argentina into the world economy.

4.1.4 Effects of Trade Reforms Argentina in the 1990s: Trade growth and trade deficits

While trade liberalization was radically advanced over the 1990s it did not lead to the productive and dynamic export sector that had been anticipated. Trade in Argentina generally increased over the 1990s but intra-regional trade increased significantly more than trade with non-Mercosur countries. By 1999 Brazil accounted for around one-third of Argentina's overseas trade (133). In both Mercosur and non-Mercosur countries imports also rose at a much faster rate than exports resulting in a trade deficit. Argentina's export to the world increased 157 percent from 1990 to 1997 while imports increased 713.81 percent over the same period (135). Exports and imports with Mercosur countries increased by 490.78 percent and 856.96 percent respectively from 1990 to 1997 (135). A central problem with foreign trade resulted from the increasingly overvalued Argentine peso, which led to growing consumer and industrial consumption of imports and a consequently rising trade deficit (139).

There was also a growing reliance on primary export commodities and a subsequent reduction of industrial exports over the period, due in part to the inability of manufacturing to compete in an unprotected market (139). Primary commodities, while they were seen to be the area in which Argentina's natural comparative advantage lay, were more volatile in terms of earnings on the world market, and produced lower quality jobs (140). While productivity increased in the 1990s in Argentina, this increase was a result of labour saving restructuring rather than a large expansion in output (141). As in the 1980s, small and medium sized firms also suffered greatly under liberalization. The evolution of trade in Argentina in the 1990s made it clear that exports were incapable of solving the economic

problems of the country and in conjunction with other reforms had actually contributed to further worsening Argentina's financial position (139).

4.1.5 Uruguay's Trade reform in the 1980s: Gradual unilateral trade reform and significant bilateral trade reform

As in Argentina, a gradual approach to trade liberalization was undertaken in Uruguay in the 1980s. In the context of the debt crisis, the newly elected democratic government under President Sanguinetti (1985-1989) planned to revive the failing economy through an export-led growth model (98). After initially increasing barriers to trade in 1985, the process of opening up the economy was quickly resumed (142). The average import tariff of 33 percent was raised to 40 percent in 1985, and then reduced again in the following years to 25 percent-30 percent in 1988-1990 (132,142). Over the 1980s the system of restitution of direct taxes that was put in place to compensate exporting firms for the negative effects of protectionist measures was slowly reduced until it was suspended in 1990. Subsidies and incentives to increase manufacturing export competitiveness were also reduced significantly (128).

While unilateral trade liberalization increased, a more important aspect of trade liberalization was Uruguay's deepening of bilateral trade agreements with Argentina and Brazil (98). A close relationship between presidents Alfonsin (Argentina) and Sanguinetti (Uruguay) and their respective foreign ministers resulted in a 1985 agreement that gave Uruguay duty-free entrance to the Argentine market for up to 5 percent of total Argentine production on a wide range of products. Under these agreements Uruguay was also allowed to export their products to Brazil after only marginal processing, whereas competitors in Argentina and Brazil were not granted the same privileges. This especially advanced chemical exportation industry in Uruguay (128). By 1990 total exports to Argentina and Brazil accounted for about 42 percent of all exports out of Uruguay (128).

4.1.6 Effects of Trade Reform in Uruguay in the 1980s: Bilateral trade boom, trade surplus and manufacturing decline

Trade in Uruguay over the 1980s resulted in a trade surplus and a contraction in the manufacturing sector that resembled trade patterns in Argentina, though bilateral trade with Argentina and Brazil played a more significant role in Uruguay. Overall exports doubled (in nominal dollar terms) from US $854 million in 1985 to US $1.6 billion in 1989. Imports increased at a slower rate, from US $675 million in 1985 to US $1.1 billion in 1989 (143). The balance of trade reached a positive US $463 million in 1989, helping offset the demands of debt service. While the growth in exports were similar in both Argentina and Uruguay much of Uruguay's increase can be credited to preferential access to the markets of Brazil and Argentina rather than to its openness to world markets (128). Bilateral agreements existed at a time when the markets of Argentina and Brazil were still protected, and most of the products covered by the agreements were not produced domestically in these two countries giving Uruguay's export industries a substantial advantage. The revival of the economy in 1986-1987 was based on demand from the sub region, and by 1989-1990 the two neighbouring countries absorbed one-third of Uruguay's exports (144). Of the export total of $1.6 billion in 1989, exports to Brazil made up US $443 million and to Argentina US $78 million (145). Non-traditional exports also only increased to the markets of Argentina and Brazil, not elsewhere (128). Uruguay's manufacturing industry, however, endured similarly negative consequences as Argentina's under the gradually increasing openness to the world, with the exception of specific industries that exported to Argentina and Brazil under bilateral agreements. GDP between 1980 and 1990 increased by 5 percent in real terms, while manufacturing GDP declined by almost 10 percent indicating the inability of

manufacturing to adjust to the opening up of the economy. Exports of manufacturing increased but only for a few highly specialized sectors and firms.

4.1.7 Uruguay's Trade Reform in the 1990s: Following in Argentina's footsteps

In 1990 the pace of trade liberalization in Uruguay accelerated and became more closely integrated with Argentine trade policy. In the first half of the 1990s unilateral trade liberalization continued to increase substantially though at a more gradual rate than Argentina. By 1993, the highest import tariff in Uruguay was 20 percent (73,144). Along with tariff reductions many nontariff barriers and sectoral privileges were removed and export subsidies were reduced.

These unilateral trade policies were accompanied by a series of regional tariff reductions as a consequence of the creation of the Mercosur (73). Mercosur was an unlooked-for and, initially at least, unwelcome development for Uruguay because it meant losing its exclusive preferences to the markets in Brazil and Argentina (144). Uruguay's entry into Mercosur followed the same regulations and process as the other member countries with intra-Mercosur tariff reductions to 0 percent by the end of 1994 and external tariff reductions scheduled to be between 0 percent and 20 percent by the year 2000. Slight differences were negotiated under the exceptions to tariffs with other Mercosur partners, in which Uruguay had an extensive list with 953 items in comparison to Argentina's 223 items. These exceptions were eliminated by the year 2000. Uruguay also had 300 exceptions to the Common External Tariff similar to Argentina, but these exceptions represented a larger proportion of Uruguay's smaller market, allowing it a slightly slower transition to world openness than Argentina. These exceptions were scheduled to converge with CET by the year 2001 (129,132,144).

Despite the greater proportion of exceptions in the CET, Uruguay's significantly smaller size placed it in a disadvantaged position relative to Argentina and Brazil in the regional agreement. (144). The more powerful economic status of Argentina and Brazil became reflected in the propensity of these two countries to alter the rules of the agreement when it didn't economically favour them (135,144,146). In 1995, for instance, only a few months after the trade agreement was in effect, financial crises in Argentina and Brazil prompted the countries to increase the tariffs in the Mercosur agreement and to expand the list of their exceptions (146).

4.1.8 Effects of Trade Reforms in Uruguay in the 1990s: Moderate trade growth, trade deficit and manufacturing decline

In the 1990s, increased liberalization and regional integration resulted in only modest growth in trade in Uruguay in comparison to Argentina's dramatic growth but, as in Argentina, it was accompanied by a debilitated manufacturing sector and an increased trade deficit. Both countries' imports in the 1990s grew at a much faster rate than exports, leading to trade deficits (135). Trade with Mercosur countries also grew significantly more than with non-Mercosur countries demonstrating that trade in the globalized market for Uruguay, like Argentina, was less successful than under the more protected regional agreement (147). From 1990 to 1997, exports and imports in Uruguay with Mercosur countries grew 228.15 percent and 299.44 percent, respectively, while with non-Mercosur countries the corresponding figures were 124.75 percent and 261.39 percent (135). Another similarity experienced by Argentina and Uruguay was the negative impact of trade liberalization on the manufacturing sectors. In Uruguay the share of total economic output in manufacturing decreased from 25 percent-27 percent at the beginning of the period to 18 percent in 1997 (73).

Table 4.1: Trade Reforms in the 1980s

1. Unilateral trade		
	Argentina	**Uruguay**
Import Tariffs	▪ Reduced from 45 percent (1987) to 29 percent (1988)	▪ Initially increased 33 percent-40 percent (1985) ▪ Reduced after 1985 to 25 percent-30 percent (1988 –1990)
Export Tariffs	▪ Reduced temporarily from 1986 to 1988 ▪ Increased 1983,1985,1989 for fiscal reasons	▪ Data not available
Non-Tariff Measures	▪ Quantitative restrictions, and specific duties eliminated	▪ Restitution of direct taxes to compensate firms reduced slowly until suspended in 1990. ▪ Subsidies and incentives to increase manufacturing competitiveness reduced
2. Bilateral Trade		
Trade Agreements	▪ 24 bilateral trade agreements with Brazil (1984-1990)	▪ Bilateral trade with Argentina and Brazil significantly increased

Table 4.2: Effects of Trade Reforms 1980s

	Argentina	**Uruguay**
Trade Balance	▪ Trade surplus (US$ 8.3 billion 1990)	▪ Trade surplus (US$ 463 million 1989) ▪ Trade surplus due to bilateral trade with Brazil and Argentina rather than openness to world markets
Imports	▪ Imports suppressed through reduced government spending, increased taxes and reduced credit availability	▪ Imports increased slowly
Exports	▪ Exports expanded sharply	▪ Exports doubled

	but still below world average annual growth rate of exports ▪ Exports were diversified	
Manufacturing	▪ Overall contraction of manufacturing sector ▪ Smaller firms disappeared, larger conglomerates expanded	▪ Contraction in manufacturing overall ▪ Manufacturing exports declined except for a few specialized firms

Table 4.3: Trade Reforms in the 1990s

1. Unilateral Reform		
	Argentina	**Uruguay**
Import Tariffs	▪ Nominal import tariffs reduced to 13 percent (1994)	▪ Highest tariff 20 percent in 1993.
Export Tariffs	▪ Export tariffs eliminated after 1990	▪ Not available
Non Tariff Barriers	▪ Quantitative restrictions on imports eliminated (1991) ▪ Export promotion mechanisms introduced (e.g. tax rebate raised to 20 percent)	▪ Non-tariff barriers and sectoral privileges removed
2. Regional Trade Reform (Mercosur)		
Intra-Mercosur Tariffs	▪ Tariffs reduced to 0 percent by 1994	▪ Tariffs reduced to 0 percent by 1994
External Tariffs	▪ Tariffs reduced to 0 percent-20 percent by 2000	▪ Tariffs reduced to 0 percent-20 percent by 2000
Intra-Mercosur Tariff Exceptions	▪ 223 exceptions – integrated in 1999	▪ 953 exceptions – ended in 2000
Common External Tariff Exceptions	▪ Around 300 exceptions – ended in 2001	▪ 300 exceptions – ended in 2001

Table 4.4: Effects of Trade Reform in the 1990s

	Argentina	**Uruguay**

Trade Balance	▪ Trade deficit	▪ Trade deficit
Imports Mercosur	▪ Grew 856.96 percent	▪ Grew 299.44 percent
Imports Non - Mercosur	▪ Grew 713.81 percent	▪ Grew 261.39 percent
Exports Mercosur	▪ Grew 490.78 percent	▪ Grew 228.15 percent
Exports Non - Mercosur	▪ Grew 157 percent	▪ Grew 124.75 percent
Manufacturing	▪ Reduction in industrial exports ▪ Small and medium sized firms suffered	▪ Manufacturing decreased from 25 percent-27 percent (1994) to 18 percent (1997)

4.2 Privatization

4.2.1 Privatization in Argentina in the 1990s: Selling off public enterprises

Privatization was an aspect of neoliberal reforms that wasn't implemented in Argentina until the 1990s due to opposition in the Senate and by provincial governors and union leaders (44,137). By the end of the 1980s, hyperinflation and increasing external and fiscal debt led to a growing acceptance by the public and political opposition that there was no alternative to the drastic reforms proposed by President Menem. In addition, labour was co-opted into accepting privatization through tactics such as allocating shares to workers in privatized enterprises (148). Given the economic crisis under which Menem became president, he was able to pass crucial legislation allowing him to bypass existing governmental institutions in order to implement his economic reforms. One of the powers he obtained in this economically pressured environment was the Economic Emergency Act, which allowed him to dissolve, unite or break up any state owned enterprises.

Starting in 1990, privatization of the public sector was swift and exhaustive. By 1993 more than 30 state public enterprises, representing the bulk of the state-owned firms, had been sold. The process covered a wide range of producers of goods and services including

telephone and communications, airline companies, petrochemicals, petroleum, about 10,000 km of highways, railways and other transport systems, natural gas distribution, electricity, water, iron and steel, coal, a series of firms in defence, hydroelectric dams, television channels, hotels, ports, silos and horseracing stadiums (149). The privatizing of traditionally public enterprises that had been established over 40 years earlier under Juan Peron represented a dramatic rupture from Argentina's nationalistic past (150).

4.2.2 Privatization Effects in Argentina in the 1990s: Short-term profits and long-term costs

Privatization over the 1990s had many short-term economic and political benefits for Menem's government(151). As state owned enterprises were often subsidized selling public enterprises allowed the government to reduce the ongoing economic burden of these enterprises on the government's yearly budget. More crucially, privatization provided substantial cash revenues that reduced the fiscal deficit and contributed to decreasing the public debt through debt–equity swap schemes that avoided resorting to inflationary financing. By late 1993 privatization had earned more than $15 billion dollars for the government from which about $5.8 billion went towards the domestic and foreign public debt (149).

On a political front, privatization also met the important goal of appeasing multilateral lending institutions who were advocating for Argentina to implement more radical reforms (59). By 1989, the IMF had suspended disbursements on its loans and privatization became a condition of the standby agreement[18] (152). In particular, the exchanges ('swaps') of foreign debt held by the public sector for equity in the privatization

[18] Standby agreements are IMF financing up to a specified amount to overcome short-term or cyclical balance of payments difficulties.

of Entel and Aerolineas were key transactions that enabled Argentina to join the Brady Plan[19] (149-151). Privatization also met the political goal of regaining support for the Argentine government from the business community. Up to 1991 Menem's application of a variety of policy measures had failed to control hyperinflation and privatization became a way of restoring the credibility of the administration by living up to the promises it had made in its election campaign.

While the short-term advantages of privatization had immediate economic and political benefits for the Menem administration, an examination of the long-term repercussions provides a bleaker picture. Privatization in Argentina was implemented under a shock-therapy approach to economic policy intended to minimize public resistance (150). As a result of the tight deadlines under which privatization occurred and in order to obtain high sale prices economic issues such as developing a pricing policy for privatized firms, or the establishment of regulatory frameworks and boards that are typically integral to privatization programs in high income countries were often forgone. In order to make public assets more attractive to private purchasers, high real rates, as well as quasi-monopolistic conditions, were also often negotiated, negating the potential competitive advantage argued to be a benefit of the privatization process (151,153). While services increased in some areas, the consequence of the rapid privatization process and the temporary influx of cash from the sales of public firms generally have been high profit rates for private owners and substantial increases in costs to the consumers (148,153). The sale, for example, of Entel, Argentina's state-owned telecommunications firm, to two new private monopolies, Telecom in the North and Telefonica in the South, resulted in price increases of over 95 percent

[19] The Brady Plan was a program that provided developing nations a way to restructure their sovereign debt obligations to foreign commercial banks.

(150). Privatization in Argentina was also undertaken in vital areas in which it would seem logical to have the public sector involved, and in cases where the sector was economically self-sustaining or profitable (148). The water sector, for example, was a public sector utility that was privatized despite the fact that it was not deficit-ridden and had actually produced a surplus in 1992.

Politically, privatization was also used to increase the concentration of economic power in the hands of the economic establishment and their political allies calling into question the ability of normal democratic procedures to remain uncorrupted (153,154). Intense political ties between Telecom and Telefonica and the Menem administration, for instance, led to a lack of Congressional consultation and public disclosure during the sale of the state owned firm Entel, and resulted in a 1993 presidential decree concerning the regulatory board Comision Nacional de Telecomunicaciones (CNT) that rendered it nearly powerless over the private companies (150). The hurried and pressured environment under which privatizations took place led to a situation in which state monopolies critiqued for their inefficiency have been exchanged for rent-seeking, privately owned oligopolies and monopolies.

4.2.3 Privatization in Uruguay in the 1990s: Preserving public provision

Privatization in Uruguay, as in Argentina, did not begin until the 1990s and even then was tempered by public and political resistance (144). The return to democracy in 1985 in Uruguay brought with it public pressure to restore a traditional political culture that supported public provision of public services. It was not until the election of President Lacalle in 1989 that a privatization agenda began to be seriously attempted. Faced with the problem of fiscal imbalance and high inflation, Lacalle in 1991 secured the passage of a privatization law authorizing the policy in general terms and setting out specific terms for

particular public–sector corporations. However, a referendum was immediately announced that resulted in a victory for the Left by 72 percent to 28 percent and led to the overturning of certain parts of the law. Privatization was not stopped entirely as the operation of the port of Montevideo and the Gas Company were turned over to the private sector, the State Insurance Bank lost its motor-vehicle insurance monopoly in 1994 and a number of in-house services in public-sector operations were contracted-out. The actual sales of public sector assets, though, were minimized to the airline Pluna, the fishing enterprise Industria Lobera y Pesquera del Estado (ILPE) and the sugar-cane operation El Esinillar(144). Despite the financial crisis facing Uruguay, voters, unions and the leftist political parties continued pushing an agenda of social protection over that of fiscal restraint.

In 1995, the newly elected president Sanguinetti (1995-2000) furthered privatization in his reform program *Bases for a Dialogue in Search of a National Government*; though once again its reforms remained less extreme than in Argentina (144). *Bases* accepted the principle of privatization subject to certain conditions. This privatization program was characterized by the concession to the private sector of ancillary activities, joint ventures between private and public enterprise and removal of monopoly powers from public corporations. Unlike Argentina the rationale of the program was to increase the level of competition within the public sector, rather than to secure the one time revenue benefit of a sale. In contrast to privatization in Argentina, the *Bases* document in Uruguay was also strategic in avoiding privatizing natural monopolies (such as water) and enterprises that were profitable. This conditional approach to privatization aided in maintaining Uruguay's democratic integrity by restricting the privatization of enterprises that would enable a concentration of economic and as a result political power to accumulate in the hands of the economic elite (144,153).

Uruguay's more moderate privatization process has not been without its own complications such as the contradictory role of regulator and competitor that public corporations now play. The process of privatization has also been critiqued for not reducing rates or requiring an improvement in the quality of service (144). In general, though, Uruguay's chosen route to privatization has been restrained by the decision to preserve public provision, which has shielded the country from the extreme socio-economic and political repercussions faced by Argentina.

Table 4.5: Privatization Reforms in the 1990s

	Argentina	Uruguay
Year Reforms Were Implemented	▪ Started in 1990 and was quick and exhaustive (largely completed by 1993)	▪ Started in 1994 with a slow and gradual implementation
Rationale of Reforms	▪ Obtain maximum profits	▪ Increased competition in the public sector rather than selling public enterprises
Extensiveness of Reforms	▪ 30 state owned enterprises representing the bulk of state owned firms privatized by 1993 ▪ Privatization of profitable sectors ▪ Pricing policies and regulatory frameworks and boards not established ▪ High real rates and quasi monopolistic conditions negotiated	▪ Concession to the private sector of ancillary activities ▪ Joint ventures between private and public enterprises ▪ Removal of monopoly powers from public corporations ▪ Limited sales occurred avoiding privatizing enterprises that were natural monopolies and enterprises that were profitable

Table 4.6: Effects of Privatization in the 1990s

	Argentina	Uruguay
Consumer Services and Costs	▪ High profit rates for private owners achieved at the expense of substantially increased costs to the consumer for public services	▪ Rates and services maintained but not improved
Short-term Economic Effects	▪ Substantial cash revenues that reduced fiscal deficit and decreased public debt	▪ Minor cash revenue
Long-term Economic Effects	▪ Lost income from economically self-sustaining or profitable sectors	▪ Maintained income from economically self-sustaining or profitable sectors
Political Effects	▪ Appeased multilateral lending agencies to allow loans to be disbursed and the Brady Plan to be joined ▪ Gained support from the business community	▪ Contradictory role of regulator and competitor

4.3 Labour Market Reforms

4.3.1 Argentina's Labour Market Reforms in The 1980s: Wage suppression, restricting workers rights, delaying collective bargaining and the erosion of unions

During the 1980s in Argentina, two contradictory trends emerged in labour relations arising from the restoration of democracy in 1983. Under the preceding military regime (1976 – 1983), the role of the state had dramatically shifted from intervening to protect

workers to regulating labour in a manner consistent with the needs of the market (72). In 1983, as a result of the debt crisis and economic restructuring under SAPs, the newly elected democratic government continued to implement market-driven labour policies rather than returning to its historical protectionist role. Labour policy in this economically turbulent time became centered on wage suppression that was intended to control inflation by reducing domestic consumption, cutting down imports and expanding exports (72). In 1985 the government implemented a new stabilization program (Plan Austral) that included freezing both wages and prices. Consistent with the government's new market oriented approach, restrictions on workers rights (e.g. relaxing limitations on collective dismissal) introduced by the military in 1976 were also continued, allowing firms to more easily adjust their labour force be more responsive to changes in their economic productivity (72).

A determining factor allowing government wage control and relaxed employment protection over the 1980s was the diminished capacity and authority of unions. For unions the return to democracy meant a return of freedom of action and political expression but also a loss of political power and influence. By 1983 the capacity of labour had been severely limited due to unemployment stemming from deindustrialization and the shift in power from social and labour ministries to ministries dealing with the economy. Under the civilian governments over the 1980s, the re-enactment of collective bargaining was repeatedly delayed and agreements were not officially recognized until March 1988. The restrictions on collective bargaining, suppression of wages, and reduction of worker's rights were resisted by the labour movement with 13 general strikes called during Alfonsin's presidency (1983 – 1989) but only minor concessions on wages and a slow lifting of restrictions on negotiations were achieved(127,155).

4.3.2 Labour Market Effects in Argentina in the 1980s: Decline in employment and income

Employment and income in the 1980s changed significantly under the effects of neoliberal economic reforms. The reforms resulted in a drastic decline in income and employment conditions that were especially severe in the second stabilization phase of 1987-90 (116). Per capita income fell by 26 percent over the decade. Overall, the decline was so severe that only countries in the midst of a revolution or civil war, such as El Salvador, Nicaragua and Peru, did as poorly (116). A key aspect responsible for the decline in income was real (inflation-adjusted) wages. From 1980 – 1989 Argentina experienced a 50 percent reduction in real wages. The worst period of the 1980s was the recession of 1988-89 in which real wages in the manufacturing sector were cut in half. The trends in unemployment show a similar pattern. Although unemployment figures in the 1980s remained relatively low, the rate increased over the decade to reach three times its historic record of 2 percent-3 percent by the late 1980s (127,156) . A further revealing characteristic of the period was the growth of informal labour and underemployment. There was virtually no job growth in the salaried or formal sector through 1987 and 82 percent of the increase in employment occurred in the self-employed (or informal) sector (116). Underutilization of the workforce, which had been relatively low in Argentina by developing country standards, showed an equally alarming pattern. In greater Buenos Aires, for example, the visible underemployment rate rose from 5.2 percent in 1980 to 9 percent in 1990 (116,127). Overall, the 1980s in Argentina was a disastrous decade characterized by significantly deteriorated income and employment conditions (97,127)

4.3.3 Argentina's Labour Market Reforms in the 1990s: Deregulating labour, decentralizing collective bargaining and diminishing union strength

The end of the 1980s brought about worsening macroeconomic conditions in the country that provided incentive for accelerating structural reforms in the 1990s. Labour policy reforms in Argentina continued the market oriented approach of the 1980s by further decreasing employment protection, reducing labour costs and weakening the role of unions in collective bargaining (41,69). The economic pressures leading the government to restrict collective bargaining and repress wages in the 1980s now focused on reducing protective labour legislation (governing wages and employment conditions) and decentralizing collective bargaining. Key examples of deregulation occurred in 1991 and 1995 in which the national labour law was altered to promote atypical or precarious forms of employment contract and reduced wage and non-wage labour costs. Under these reforms, employers were exempted from payroll taxes for social security and unemployment insurance, the ceilings on compensation for unjustified layoffs were lowered, salary increases were linked to productivity and regulations on the termination of employment and mobility within the firm for short-term contracts and employment were eased.

Key factors enabling neoliberal labour policies to be implemented over the 1990s were the aggressive strategies used by the Menem government (1989-1995) to undermine the status of labour associations and the role of unions in collective bargaining (41). Government policy after 1991 focused on decentralizing collective bargaining and dividing and weakening labour unions. Legislation was modified to encourage small firm negotiation rather than industry wide agreements to allow for increased inequality in wages that would better reflect the productivity of individual firms. Barriers to the existence of more than one national labour confederation were also removed and the role of union leadership in negotiations was reduced. Unions were also financially weakened by a new law that ended the compulsory contribution by workers to the unions' obra (national union) social funds.

Opposition to Menem's anti-labour policies was also sidestepped through forceful political maneuvers. Right-to-strike restrictions, for instance, that found no support in Congress, were implemented by administrative decree. The cumulative effect of these reforms over the 1990s was a substantially fragmented and deregulated collective bargaining system with a significantly weakened and decentralized union structure.

4.3.4 Labour Market Effects in Argentina in the 1990s: Unemployment, precarious employment, underemployment and wages

In the 1990s, the acceleration of neoliberal reforms led to renewed economic stability and growth but did not generate the anticipated improvements in employment and income (139). While the economy grew rapidly between 1991 and 1994, unemployment increased from 6 percent to over 12 percent (43,139). Part of the explanation for this phenomenon was the low generation of jobs and the increased number of people looking for work. Privatization of state firms and the acceleration of trade liberalization resulted in the reduction of state employment and the contraction of employment in manufacturing. Rising unemployment was also related to the growing number of people seeking employment due to increasing incidence of unemployment in heads of the household that forced other members of the family and especially women to increase their participation in the labour market (139).

From 1991-1995, women's labour force participation rates grew sharply from 38 percent to 46 percent and from 1985 to 2000 it rose by almost 40 percent (157). With the coming of the recession of 1995/1996 unemployment increased sharply jumping from 10.1 percent in October 1994 to 18.4 percent in 1995 (156,158). While some of this increase may have been connected to the recession, a greater part of the growth in unemployment was structural, resulting from contraction in the manufacturing sector as it continued to adapt to

trade liberalization, i.e. a loss in traditional male employment (130,139,156). From 1996 to 1998 unemployment rates dropped, reaching 12.4 percent in October 1998, but never achieved pre-recession levels (155,156). Another factor discrediting this apparent recovery was that a sizeable proportion of the jobs created during this period were also due to the implementation of special employment programs, which were characterized by very low wages and low productivity, and were only offered on a temporary basis. These programs were responsible for 80 percent of new employment in the public sector (155). With the recession of mid-1998 Argentina's labour markets eroded further and unemployment reached 14.7 percent in 2000.

Unemployment in the 1990s was accompanied by a steady increase in precarious employment, underemployment and reduced wages. In the area of Metropolitan Buenos Aires the number of jobs in the informal sector represented 26.7 percent out of total salaried employment in 1990, 36 percent in 1998 and by the year 2000 it had reached 40 percent. As many as two-thirds of the jobs lost during the period resulted from reductions in employment in the manufacturing sector; as the industrial sector continued to represent only 17 percent of GDP in 1998. The quality of employment in Argentina also deteriorated due to the growth of temporary employment. Nearly half of the private-sector employment growth in metropolitan Buenos Aires, for example, can be explained by the expansion of limited-term positions. Underemployment also continued to be a reality in the 1990s growing from 7.9 percent in 1991 to 11.3 percent in 1995 (130,157).

In addition, real wages continued to suffer over the 1990s. Despite an initial recovery from 1991 to 1993 and wage stabilization in 1994, from 1995 onwards real wages continued to fall. Even at their peak, real wages stayed below the levels of the previous decades (139,159). The 1990s thus were characterized by increasing unemployment, decreasing

wages, and job instability associated with the increased implementation of structural adjustment policies since 1991 (157).

4.3.5 Labour Market Reforms in Uruguay in the 1980s: Restoring collective bargaining and wages

Uruguay, like Argentina, faced economic conditions of debt and rising inflation in the 1980s. Economic reforms in Uruguay, however, were tempered by political and union pressure to address public social and health concerns that had eroded under the military government(160). A key difference in the development of labour policy over the 1980s was that, unlike the gradual return of collective bargaining in Argentina, Uruguay's unique system of Wage Councils banned under the previous military government was reinstated in 1985 with the return to democracy. The newly elected government also initially committed to promote a recovery of real wages, which had been decimated under the military; and to reinstate all public-sector employees who had been dismissed by the military regime for their union activity. Toward the end of the 1980s, the government's initial commitments to wage recovery were constrained by increasing indebtedness and the need to control inflation. Addressing economic concerns through wage restrictions in Uruguay, however, was never as drastic as in Argentina, partly due to strong resistance by trade unions. Attempts to reduce wage increases to 90 percent of inflation in 1988, for example, were met by labour protests, which also effectively prevented imposition of a tougher regime of wage adjustments in 1989 (144). Thus, while the general approach to labour market reform under democratic government in the 1980s paralleled Argentina's, Uruguay's reforms were more gradual and less intense, largely due to political and trade union opposition (147).

4.3.6 Effects of Labour Market Reforms in Uruguay in the 1980s: Income and employment recovery

In contrast to Argentina whose employment conditions worsened over the 1980s, Uruguay entered the 1980s with high levels of unemployment and low real wages but moved towards improved salaries and reduced unemployment after the transition to democratic government in 1985. Real wages in Uruguay over the second half of the 1980s recovered some of the loss they had undergone under the military dictatorship. With the restoration of democratic government in 1985, real wages were raised an average of 15 percent over the previous year. Over the rest of the decade wages were increased slowly though they never regained their 1968 levels (145).

The pattern of unemployment in Uruguay over the 1980s also differed from that of Argentina. While in Argentina the unemployment rate started low at the beginning of the decade and increased toward its end, in Uruguay unemployment started high at 13.9 percent in 1980-1981 in Montevideo, fell to 9.3 percent in 1987 and then held steady at around 9 percent until 1990 (116,127,144,147). A key factor explaining the difference between the two countries was the condition of the manufacturing sector. In Uruguay employment in manufacturing grew until 1989 while in Argentina manufacturing employment suffered a considerable decline over the 1980s (147,161).

4.3.7 Labour Market Reforms in Uruguay in the 1990s: Gradual decentralization and weakening union support

Like Argentina, Uruguay experienced worsening economic conditions in the 1990s with increasing external pressure to implement structural reforms. In response to the eroding economic conditions Uruguay adopted market driven labour policies but, in contrast to Argentina's sharper reform process, implementation was gradual. Uruguay historically had

not legislated union and workers' rights, although union activities were virtually unchecked and union rights had been guaranteed by custom and usage for decades, except during the military dictatorship (98). Government efforts to marketize labour thus concentrated on decentralizing wage setting institutions, primarily by withdrawing itself from the trilateral Wage Councils in 1992 to encourage decentralized bipartite (employer/employees) negotiation (72,147). After 1992, membership in unions and union dues also became voluntary significantly reducing membership in the private sector (147). Overall in the 1990s the reforms to collective bargaining and union associations adopted in Uruguay followed Argentina's stand of increasing marketization, but the less aggressive steps taken to expand decentralized negotiation and weaken union strength led to a slower and less severe transition than in Argentina.

4.3.8 Effects of Labour Market Reforms in Uruguay in the 1990s: Declining income and employment conditions

During the 1990s the condition of employment and wages in Uruguay began to more closely reflect Argentina's situation, as neoliberal economic reforms in the two countries became more aligned. As in Argentina, economic growth in the 1990s in Uruguay did not bring about the expected improvements in labour conditions, though Uruguay fared somewhat better. Between 1989 and 1993 there was a modest upward movement of the urban unemployment rate followed by a sharp rise persisting for three years to mid-1997 (144). Unemployment increased to 11 percent in 1995 and 12 percent in 1996-1997 (147,161). The growth in unemployment over the decade was partly due to the adaptation of the manufacturing industry to liberalization, which caused the loss of over 12,000 jobs between 1994 and 1997 as a result of closures and increasing productivity (144). Public sector cuts also help to explain a significant portion of the jobs lost as on average 6,000

public-sector posts were eliminated annually after 1993 (144). Like Argentina, Uruguay's unemployment rate was also affected by greater labour force participation and especially the growing participation of women over the 1990s who sought employment in order to supplement dwindling household incomes (144,162). Following 1997 Uruguay continued to experience increasing unemployment rates that jumped to 13.8 percent in 2000 following the shocks from East Asia, Russia, and Brazil in 1998 (130,162,163).

Over the 1990s the pattern in real wages, underemployment and precarious employment followed a trend similar to unemployment. While wages and income demonstrated an improvement during the early part of the 1990s from 1995 onwards they fell (144). Real wages dropped 4.8 percent in 1995 and an additional 3.2 percent in 1996 (144). The explanation for increasing wages in the early part of the decade was due in part to the significant increase in pensions that took place as a result of the 1989 referendum rather than the growing value of salaries (144). As with real wages, underemployment and precarious employment drastically worsened after 1994. In Montevideo, precarious employment went from 13.7 percent of total employment in 1994 to 16.7 percent in 1998. In looking at the characteristics of the labour market over the 1990s it becomes evident that despite the high annual average growth rates the acceleration of neoliberal economic reforms has had significantly negative impacts on working conditions in Uruguay.

Table 4.7: Labour Market Reforms in the 1980s

	Argentina	Uruguay

Wages	▪ Wages frozen in 1985 with small concessions in wages over the decade	▪ Initial recovery in wages in 1985 ▪ Only minor restrictions in wages due to union opposition
Collective Bargaining	▪ Re-enactment of collective bargaining delayed until 1988	▪ Wage councils reinstated in 1985 ▪ Public sector employees dismissed under military for union activity reinstated
Workers Rights	▪ Reductions in workers rights introduced under military were continued	▪ N/A (workers rights were not legislated in Uruguay)

Table 4.8: Labour Market Reforms in the 1990s

	Argentina	**Uruguay**
Wages	▪ Salary increases were linked to productivity	▪ Not available
Collective Bargaining	▪ Decentralized collective bargaining – legislation modified to encourage small firm negotiation over industry wide agreements ▪ More than one national union allowed to exist ▪ Role of union leadership in negotiation reduced ▪ Compulsory contributions to unions ended	▪ Membership in unions and union dues were made voluntary ▪ Encouraged decentralized wage setting institutions by the government withdrawing from Wage councils in 1992
Workers Rights	▪ Regulations on the termination of employment and mobility within the firm for short-term contracts and employment were eased ▪ Employers exempted from payroll taxes for social security, unemployment insurance ▪ Compensation for unjustified layoffs reduced	▪ Not Applicable (workers rights not legislated in Uruguay)

	▪ Right to strike restrictions implemented by Administrative Decree	

Table 4.9: Effects of Labour Market Reforms in the 1980s

	Argentina	Uruguay
Per capita income	▪ Decreased	▪ Not available
Real wages	▪ Decreased	▪ Increased
Unemployment	▪ Started low with an increasing trend	▪ Started high with a decreasing trend
Precarious employment	▪ Increased	▪ Not available
Underemployment	▪ Increased	▪ Not available

Table 4.10: Effects of Labour Market Reforms in the 1990s

Effects of Labour Market Reforms 1990s		
	Argentina	**Uruguay**
Unemployment	▪ Increased	▪ Increased
Precarious Employment	▪ Increased	▪ Increased after 1994
Underemployment	▪ Increased	▪ Increased after 1994
Real Wages	▪ Initial recovery ▪ Decreased (1995 – 2000)	▪ Initial recovery ▪ Decreased (1995 – 2000)

4.4Pensions

4.4.1 Pension Reforms and Effects in Argentina in the 1980s: Growing financial imbalances

In Argentina the growing financial burden of the pension system became a key social policy issue in the 1980s and 1990s. A pension system was first introduced in the early 1900s in Argentina financed primarily with payroll taxes; later the system adopted a defined-benefit scheme[20] funded on a pay-as-you-go basis (77,80,164). Argentina provided widespread pension coverage and generous benefits in comparison to most other Latin American countries, but was critiqued because it allowed privileged groups within the system and because it required increasing public investment (24,77,165). Many factors contributed to the increasing costs of the system, including: an aging population (number of contributors to pensioners 1.62 to 1); lax entitlement conditions; a short period of wage averaging to determine benefits; easy access to disability benefits; high replacement rates (70 – 82 percent of wage received in pension); and high payroll taxes that promoted underreporting of income and evasion (77,166).

The government responded to emerging financial imbalances in the 1980s by diverting more tax revenues to the system and cutting back on benefits by reducing the adjustment for inflation (77). Real pensions actually declined by one half in 1981-1991, but successful judicial claims forced the government to retroactively pay pensioners the difference between the pension legally set and that actually paid (24). In 1991 the state settled the debt to pensioners at $7 billion (24). Despite the retroactive payment of pensions in the 1990s, the financial crisis and fiscal austerity measures of the 1980s resulted in serious

[20] Defined benefit scheme means benefits are set at a certain level determined by the scheme rules and aside from compulsory employee contribution all costs of meeting the quoted benefits are the responsibility of the employer

reductions to the funding of pensions over the 1980s, increasing the financial burden for a large segment of the Argentine population.

4.4.2 Pension Reform in Argentina in the 1990s: Pension privatization (mixed model)

During the 1990s Menem's government inherited a country with severe inflation problems and a growing fiscal deficit that was being further threatened by increased spending on public pension programs. Social security program spending equalled 13 percent of GDP in 1991 of which 80 percent was in pensions (24). Coinciding with these financial pressures, the World Bank as a part of their larger SAP offered support to pension privatization by providing financial and technical assistance in reforming the pension system (81,156). The IMF also included pension privatization plans in the lending agreements that it signed with Argentina (83). In the context of these economic and political pressures a new system was put into operation in 1994. The new system offered two tiers: a basic pension and a choice between a public pay-as-you-go pension and a personal retirement accounts program (166).

With the goal of slowly replacing the old financially strained pay-as-you-go system with a new partially funded pension system workers who chose the pay-as-you-go system were allowed to switch to the private accounts system at any time, but they could not return to the pay-as-you-go system once they had chosen private accounts (166). Workers who did not choose between the alternatives were also put into the personal accounts system by default (166). In the new scheme, while the basic pension would remain a public pay-as-you-go system, membership in the complementary pension would ideally gradually transition to the private fully funded account system (166).

The new system aimed to decrease its public financial burden by shifting part of the risk of future increases in costs from the state to individuals (167). The old pay-as-you-go

system had operated under a defined-benefit scheme that meant that the employer would underwrite the vast majority of costs; if investment returns were poor or costs increased the employer needed to either make adjustments to the scheme, or to increase the levels of contribution (24,164). The new system of private accounts had a defined-contribution scheme in which contributions were paid at a fixed level; the member had to shoulder the risk and increase the contribution rates when investment returns were poor or costs increased (24,164).

In addition to the structural changes the system's parameters[21] were also altered to reduce costs. The employee's contribution rate rose from 10 percent to 11 percent, the minimum retirement age was raised by five years from 55 to 60 for women and 60 to 65 for men, the number of years of contributions required to obtain retirement benefits were increased from 20 to 30 years, and the expected replacement rate reduced from 70 to 82 percent of the average of the previous three years of wages to an average of approximately 60 to 82 percent of the average of the previous ten years of wages (167). A few groups remained exempt from the system: employees of the armed forces and of state and local governments and certain professionals with independent retirement systems (82).

4.4.3 Effects of Pension Reform in Argentina in the 1990s: Economic and social deterioration

A key effect of Menem's pension reform was increased fiscal spending by the government (167,168). The total fiscal impact (that is, cost to the national government) of the reform was an increase from 1.4 percent of GDP in 1995 to 2.7 percent of GDP in 2001 which clearly played a role in the Argentine government defaulting in 1995, 1997 and 2000 on parts of the pension rights owed to workers and retirees (79,82,165). Anticipated

[21] Parameters are the investment ratios, and criteria for receiving benefits.

reductions in administrative costs were not achieved with the reform and payroll contributions fell rather than improved (167-169). Stricter conditions for receiving benefits did result in fiscal savings; but transition costs, the reduction in employers' contributions, the redirecting of contributions to the private funds and the absorption of 11 pension schemes for public employees from the provinces resulted in drastic overall increases in fiscal spending (165). In December 2001, in the face of economic collapse, the government seized $3.1 billion in pension fund deposits and converted them into treasury bills that devastated the finances of the reformed pension fund (79).

In addition to the system's economic problems, social protection and equity were further deteriorated by the pension reform. Coverage of workers fell from 1994 onwards mainly due to the erosion of conditions in the labour market combined with the stricter conditions for the acquisition of benefits (outlined above) (165). Increasing unemployment, employment policies that permitted the recruitment of new workers free of the obligation to pay social security contributions and increases in informal employment all contributed to decreased coverage (165,167). In 1993 the percentage of people older than 65 who had no pensions of their own or through their spouses was 12.5 percent, increasing to 22.7 percent in 2001 (165,167). Coverage rates in Argentina based on affiliates[22] fell in Argentina from 70 percent – 80 percent before the reform to 66 percent after the reform (168). This figure also overestimated coverage as only 29 percent of affiliates actively contributed to pensions in 1998 (167,168).

[22] Affiliates are the number of people registered with pension plans; the number of affiliates may not reflect the actual pension contributors due to noncompliance, double counting, temporary workers who only make payroll contributions occasionally or have permanently left the labour force and high unemployment rates.

The fully funded component in the mixed scheme also has been found to increase gender inequalities and to most negatively affect low income workers. Due to the calculation of life expectancy factors those who lived longer (women) obtained on average 10.5 percent lower benefits than those whose life expectancies were shorter (men) (77). The workers most affected by reduced coverage were also the least skilled exacerbating the inequalities in work income (165). Reforms to the pension system in Argentina in the 1990s thus encountered ongoing economic problems and led to worsened coverage and increased inequities (166).

4.4.4 Pension Reform in Uruguay in the 1980s: Growing financial imbalances

Uruguay, like Argentina, has one of the oldest and most indebted pension systems in Latin America that by the 1970s had developed to be more generous and to cover more people than in most other Latin American countries (170). By the 1980s a combination of high retirement benefits, reduced payroll revenues, widespread coverage, early retirement and an aging population all contributed to the growing pension deficit (24). In 1982 the pension deficit was 6 percent of GDP and reached 10 percent of GDP by the mid 1980s, making it the most debt-ridden system in Latin America (171).

Despite the growing costs of pensions, the election of a democratic government in 1985 brought efforts to restore some of their real value. Between 1984 and 1987 pensions grew 20 percent in real terms (143,171). After 1987 though, the government began to take measures to try and reduce pension costs. In 1987 a new law tightened some of the liberal conditions of the privileged regimes by setting a ceiling on maximum pensions, but failed to raise the retirement age from 55/60 (women/men) to 60/65. Two years later a constitutional amendment repealed the ceiling on pensions and required that all pensions be linked to the cost of living. This measure required significant increases in taxation. Overall, Uruguay, like Argentina attempted only minor reforms to the pension system over the 1980s but had

greater success than Argentina in restoring some of the real value of pensions. Entitlement conditions remained very generous, and the liberal coverage and benefits it offered continued to raise the pension deficit (24,170).

4.4.5 Pension Reform in Uruguay in the 1990s: Pension privatization (mixed model)

In the 1990s a similar pension reform as in Argentina was initiated in Uruguay but political resistance delayed its implementation until the late 1990s. Attempts to reform the pension program (with a mixed type) failed in 1992 but were eventually passed in 1995 and implemented in 1997 (24,172). As in Argentina, growing deficits in the pension system, political pressure by the World Bank and the Inter-American Development Bank and encouragement from both in the form of transition loans played a key role in achieving the pension reform (76,81).

Uruguay introduced a pension system similar to Argentina's, replacing the public pay-as-you-go system with a two tier system, combining a compulsory reformed public pay-as-you-go program that provided a basic pension with a supplementary fully funded program with individual accounts (24). All members of the system who were under 40 years of age and any future entrants of the labour force were obligatorily covered by the new system (24). Unlike Argentina's defined contribution scheme Uruguay has a defined benefit scheme that was adjusted for inflation, meaning that if investment returns were poor or costs increased the employer, and not the employee, needed to either make adjustments to the scheme, or to increase levels of contribution (24,164).

In addition to structural changes, Uruguay, like Argentina underwent some parametric reforms. The retirement age was set at 60 for both sexes (female age of retirement increases gradually from 55 to 60) with 35 years of work/contributions required (24) and the employer's contribution was reduced by 2 percent while employee contributions

rose 2 percent (24,144,170). In exchange for the payroll tax cut, employers are required to raise employee pay so their take-home earnings after social security taxes will remain the same as before (170). Uruguay's reforms, like Argentina's failed to alter pensions of privileged professions including university professionals, bank employees and notaries; and left the generous military and police pension funds unchanged by the reform (82,173).

4.4.6 The Effects of Pension Reform in Uruguay: Economic and social deterioration

Drawing comparisons between the effects of reform on Argentina and Uruguay is difficult because of the differences in data collection and the recent timing of the reforms; but early evaluations indicate that Uruguay, like Argentina, is experiencing ongoing financial problems and also an increased risk to social integration. The fiscal effects of reforms were estimated to have remained high at around 2 percent of GDP in 2001, a level similar to that of Argentina's (84). A part of reason for continuing fiscal problems were reduced compliance to payroll contributions and high administration costs. While data on compliance before the reform was not available it was estimated to have fallen to 59 percent in 1999 and administrative costs remained high at 2.68 percent of taxable income in 1999-2000 (168,169).

While little data on the social repercussions of the reform were available, initial evidence demonstrated that social protection was not improved and may have worsened following the reform though its later implementation delayed these negative effects. At the beginning of the 1990s, the real value of pensions in Uruguay increased dramatically with the constitutional amendment in 1989 falling later in the decade (24,172). Coverage rates in Uruguay remained unchanged by the reform continuing at around 72 percent of affiliates by the end of 1998 (84,168). However, of these affiliates coverage rates of active contributors in 1998 dropped slightly in Uruguay to 66 percent. While implemented at a later date, pension

reform in Uruguay adopted a similar system to Argentina that resulted in continuing financial problems and endangered social protection.

Table 4.11: Pension Reform and Effects in the 1980s

<table>
<tr><th colspan="2">Reforms</th><th colspan="2">Effects</th></tr>
<tr><th>Argentina</th><th>Uruguay</th><th>Argentina</th><th>Uruguay</th></tr>
<tr><td rowspan="2">▪ Benefits were cut by reducing the adjustment for inflation. This decision was repealed in 1991.</td><td rowspan="2">▪ Efforts made to increase real value of pensions with return to democracy

▪ Ceiling on pensions implemented in 1987 and repealed in 1989</td><td>Real value

▪ Declined 1981-1991</td><td>Real value

▪ Increased 1984 - 1987</td></tr>
<tr><td>Fiscal Costs

▪ Increased</td><td>Fiscal Costs

▪ Increased</td></tr>
</table>

Table 4.12: Pension Reform in the 1990s (Mixed Model)

1. Structural Reform	Argentina	Uruguay
Financial Regime	Public – Pay-as-you-go & Private – Full individual funding	Public – Pay-as-you-go & Private – Full individual funding
Year Implemented	1994	1996
Contribution	Public – Non-defined Private – Defined	Public – Non-defined Private – Non-defined
Benefit	Public – Defined Private – Non-defined	Public – Defined Private – Non-defined
Present Members	May change from public to mixed but not return	Grouped by age; under 40 to join mixed and older allowed to choose
Future Members	May choose between public and mixed	Must join mixed
Privileged Pension Schemes (certain professionals, civil servants, military and police)	Unaltered	Unaltered
2.Parametric Reform	**Argentina**	**Uruguay**
Retirement Age	Increased Men – 65, Women – 60	Increased Men – 60, Women – 60
Years of Work/Contributions Required	Increased to 30 years	Increased to 35 years
Employees Contribution	Increased 1 percent	Increased 2 percent
Employers Contribution	Unchanged	Decreased 2 percent
Replacement Rate	Decreased to 60 percent - 82 percent of the average of the previous ten years of wages	Not Available

Table 4.13: Effects of Pension Reform in the 1990s

1. Economic	Argentina	Uruguay
Fiscal Costs	Increased to 2.7 percent GDP (2001)	Unimproved around 2 percent GDP (2001)
Administrative Costs	Unimproved 3.41 percent taxable income (1999-2000)	Unimproved 2.68 percent taxable income (1999-2000)
Payroll Compliance	Decreased – active affiliates 44 percent (1999)	Decreased - active affiliates 59 percent (1999)
2. Social	**Argentina**	**Uruguay**
Coverage	Decreased affiliates 66 percent (1998) active contributors 29 percent (1998)	Unimproved affiliates 72 percent (1998) active contributors 66 percent (1998)
Inequities	Least skilled most adversely affected	Not Available
Women/Men	Women receive 10.5 percent lower benefits than men	Not Available

4.5 Health Care Systems

4.5.1 Health System Structure in Argentina

Argentina's health care system is made up of three main financiers and administrators: public health care, social insurance organizations (Obra Sociales) and private institutions operating on a for profit and not for profit basis (174,175). The social insurance system was made up of a large number of separate funds that were supported by mandatory taxes paid by every active worker. Given the fragmentation of the social insurance sector, most funds were too small to provide services, and so they contracted out to private clinics and hospitals creating a large private provision sector. Private institutions were supported mainly by payment from private health insurance companies and by arrangements made with social insurance organizations (176). Up to the 1970s public hospitals were the dominant health care providers in Argentina. In the 1970s and 1980s the predominance of public hospitals began to decline and large unregulated private hospitals began to flourish (174).

These hospitals provided voluntary schemes mainly for high-income groups, supplementing the cover they were obliged to take with *Obras Sociales* (175).

4.5.2 Health Care System in Argentina in the 1980s: Economic instability and organizational pandemonium

By the 1980s Argentina had inherited a health care system with a variety of structural and economic problems. Investment in health care in the beginning of the 1970s had increased, but after the military coup in 1976 the public health system became a target of budget cuts (177,178). Structurally, Argentina's health system had many problems that jeopardized the quality and efficiency of care (177). Due to the complex and unplanned development of the health system, services lacked co-ordination among providers that resulted in a duplication of infrastructure, equipment and specialties in some areas with shortages in others (67). Expenditures were planned and executed by a large number of institutions at federal, provincial and municipal levels of government, and were poorly coordinated and managed. Added to these problems were the economic problems of high inflation that led to budget fluctuations and delays, creating serious difficulties for health care personnel in planning and service delivery (67). A lack of regulation also led to inefficiencies in the private sector such as overstaffing doctors and performing more costly procedures than necessary (67).

Argentina tried to address the economic deficiencies of the health system with the return to democracy in the 1980s. Expenditures to health care, both public and private, increased from around 7 percent of GDP in 1970 to 9 percent of GDP in 1986 (179) but fell again to 7 percent of GDP in 1989 (67,177). While health expenditure in the 1980s was relatively high serious deficiencies remained and the country continued to spend more on defence than on its public health and educational systems combined (177,179). Financial

shortages led many *Obras* health funds to establish or to increase the size of co-payments, placing a greater burden of health care costs on the individual (67).

The finances invested in health also did not translate into improved care because of the financially constrained circumstances of the 1980s and the operational difficulties that remained unaddressed in the health sector (67). Public hospitals and national health programs continued to be transferred to the provinces over the 1980s in order to ameliorate the organizational problems, but without much success. Appeasing economically powerful interests also constrained the ability of the government to improve the mismanagement in the health sector (67,178). An attempt by the health minister to set up a commission to monitor the high cost and low scientific value of the pharmaceuticals sold in Argentina was dissolved due to the economic influence of the pharmaceutical industry despite the obvious benefits this would have had on a financially burdened health system (67). Building on the diminished investment and organizational inefficiencies of the 1970s, economic instability, structural disorganization and political cooption further eroded health care in Argentina in the 1980s (177).

4.5.3 The Effect of Economic and Organizational Deterioration in Argentina in the 1980s: The poor pay the price

The continued erosion of the health system during the 1980s was felt most acutely by the more vulnerable sectors of society (177). Public health care in Argentina suffered dramatically over the 1980s to the point where it almost ceased to function and failed to provide even minimal services to the population under its care. An accumulated deterioration over many years in management, infrastructure and wages was aggravated by the hyperinflation of 1989-90, to the point that in the latter year the Ministry could not buy vaccines, and maintenance of this crucial program depended on emergency help from

UNICEF (179). In 1987 an estimated 25 percent of public health care capacity for short-term patient care was dilapidated beyond repair, and another 25 percent required extensive upgrading; while 50 percent of long-term care public hospital capacity was totally obsolete (67).

Diminishing capacity in public health care coincided with an increase in the prevalence of private care facilities that further aggravated the inequities in the system by attracting physicians and other health care staff away from public institutions. Increases in unemployment and informal workers during the 1980s also expanded the number of patients from lower-middle class households that used public hospitals as well as reducing real revenues for many *Obras* through the reduced insurance contributions. Individual health care costs also increased due to the introduction of co-payments in the *Obras* health funds. The economic crisis of the 1980s resulted in increasing inequities, inefficiencies and consumer costs in a health care system already suffering from a lack of coordination, investment and accountability (174).

4.5.4 Health Care Reform in the 1990s: Introducing competition into the health insurance sector

The successful implementation of neoliberal policies under Menem's administration in the 1990s paved the way for the introduction of health reforms in Argentina. While there was some resistance to health reforms, unions had been weakened over the 1980s and remaining opposition was overcome by allocating funding to union groups from World Bank and treasury funds to implement insurance reforms. The main goal of the reforms was to introduce competition into the health insurance sector (176). In 1991 and 1993 legislation gave the *Obras Sociales* greater freedom to negotiate contracts with health care providers. In November 1996 the government provided a basic package of services, which all funds were

obliged to provide. The following January all insurance affiliates were given the right to select their funds and from January 1998 private insurers were permitted to compete for these affiliates on an even footing. In the public sector a separate set of reforms was developed with the main goal of increasing the financial independence of hospitals and recovering costs from insured groups that used public facilities (175).

4.5.5 The Social and Economic Implications of Reforms in the 1990s: Coverage, inequality, and cost containment

Changing patterns of coverage have worsened health care provision in Argentina since the implementation of reforms. The number of people covered by the *Obras Sociales* fell during the 1990s, while private and public provision increased. Despite the economic growth that occurred in the 1990s, many workers lost insurance protection because of a shift to short-term contracts and part-time employment (175,180). In addition there were large reductions in public sector jobs and unemployment reached unprecedented levels. In contrast, the private health providers experienced a marked increase in affiliation while the public sector remained the provider of last resort for a large proportion of the population. The decrease in coverage by the *Obras Sociales* meant that a greater financial burden was placed on those who could afford private care as well as a reduction in quality of services for those who had to turn to the dilapidated public system.

Inequalities in access to health services also increased. As a result of the introduction of increased competition into *Obras Sociales*, higher profits were attained by attracting higher income workers through targeted marketing while placing obstacles to coverage for less attractive groups. Private insurers also intentionally sought out more affluent groups. Even public hospitals had increased incentive to treat as many insured individuals as possible after reforms, to the detriment of the rest of the population, since costs recovered by

insurance were not deducted from their core budgets (175). Barriers to accessing care also increased in both private and *Obras Sociales* health care systems due to co-payments, private practitioner's refusal to see patients due to nonpayments by social insurance funds and confusion in the assignment of providers (180). Public institutions intended to insure basic health care provision in the country also became more difficult to access. In order to apply for free care at public institutions patients had to undergo lengthy means testing, with a rejection rate at some hospitals that averaged between 30 and 40 percent.

Finally an examination of the major goal of reforms, cost containment, provides a mixed picture. On the one hand reforms seem to have increased competition and efficiency in some areas. By 1999 the total number of *Obras Sociales* organizations had fallen from 320 to around 200, and most of those that had disappeared had small client bases and relatively high administration costs. Public hospitals after reforms also became more financially autonomous increasing incentives to recoup costs from insurance funds (175). On the other hand efficiency was lost with the take-over of the administration of public institutions by for profit managed care organizations in the 1990s, which increased administrative costs and as a result diverted funds from clinical services. To attract patients with private insurance and social insurance plans, Buenos Aires' public hospitals hired management firms that received a fixed percentage of billings (180). Public investment in health care also increased due to reforms as both *Obras Sociales* and public health care providers covered an increasingly large proportion of low income, and high risk groups that could not afford or did not qualify for private care. Further, the private sector accounted for a disproportionate and rising share of total health expenditures estimated at around 42 percent in 1996.

The deteriorating health care system over the 1990s culminated in 2001 and 2002 in Argentina in a health crisis(181). Pharmacies suspended care due to the inability of social services to repay debts. Laboratories, drug companies and pharmacies, increased prices exorbitantly as a result of the devalued peso. Already deteriorated public hospitals that were facing greater demand due to increased poverty collapsed, due to the shortage in their reserves of essential drugs and basic supplies. Many hospitals had to implement a system of exchange of materials to ensure their operation (88).

4.5.6 Health System Structure in Uruguay

During the first half of the twentieth century, Uruguay led Latin America in its advanced standards of medical care (182,183). The health system in Uruguay by the 1980s consisted of a complex system of publicly run health care facilities, private providers, insurers and a variety of financiers. Care was financed through the public sector, the social security health insurance system (Mutual benefit funds) managed by the Direccion de los Segouros Sociales por Enfermedad (DISSE), the regulated not-for-profit sector Institutos de Asistencia Medica Colectiva, (IAMCs) and the private for-profit sector (184). The various public and private institutions purchased services from and sold services to each other, which resulted in strong ties among these public and private actors(182,183).

4.5.7 Restoring Health Care in the 1980s

Health care in Uruguay declined sharply under the military government between 1973 and 1985 but a reinvestment in health by the democratic government elected in 1985 made considerable progress in restoring its services. While overall public health care spending had been generous under the military, funding had been redirected from public facilities toward military hospitals which were open only to relatives of the members of the armed forces (145,185). In 1984 total health care spending represented 8.1 percent of GDP,

a proportion similar to that of high income countries, but 400,000 Uruguayans were without state or private health care coverage, a substantial proportion of the population of 2,989,000. After 1985 the newly elected democratic government made a sustained effort to increase health care coverage and to redirect spending from the military to social welfare. Total spending by the Ministry of Public Health rose dramatically, increasing 34 percent in real terms from 1985 to 1987, while defence spending was reduced from 13 percent in 1984 to 11.8 percent in 1986. In addition, in 1984 all people who worked in the formal sector acquired the right to subscribe to a Mutual Benefit Fund and this obligatory health insurance was managed by a new office the DISSE.

Unlike Argentina, increased spending was not due to operational difficulties but reflected greater government investment in health care facilities, coverage, equipment and medications. From 1985 to 1988 public health care card holders increased from 566,000 to 692, 000 in the interior but decreased slightly from 323,000 to 310,000 in Montevideo. From 1984 to 1988 there was also a 17 percent increase in the membership in the Mutual Benefit Funds. Along with increased coverage the Mutual Benefit Funds were redistributive in that they required the amount of money that was taken out of your salary to be proportional to that salary (185). As with the state health provision, the greatest increase in coverage also occurred in the interior where it was most needed. A key example of greater investment in public health was the efforts made to increase the proportion of infants receiving inoculations. The proportion of infants immunized before age one rose from 61 percent to 79 percent in 1985 to 80 percent to 88 percent in 1987, depending on the particular vaccination. In contrast to declining health care delivery in Argentina over the 1980s, overall investment and services in health care in the 1980s in Uruguay improved dramatically with the return to democracy in 1985.

4.5.8 Health Care in the 1990s: Economic hardship and declining care

In the 1990s health care in Uruguay did not undergo structural reforms as it did in Argentina, but economic constraints led to some policy adaptations (24,185). The increase in health coverage by the Mutual Benefit System over the 1980s added financial strains on a system that had already been experiencing economic problems (185). Strong state subsidies were provided to cover the increased costs in the Mutual Benefit System that consequently decreased the amount of money that could be allocated to the public system that was also experiencing increased usage (182,185). Some of the additional economic burden of the increased coverage was also passed on to members of the social insurance system through the increase of co-payments.

Uruguay's more moderate approach to health reforms managed to shelter the country from deteriorating into the health care crisis experienced in Argentina though Uruguay's health system also declined over the 1990s. Economic problems persisted and inequities increased over the decade but coverage increased and service delivery was maintained. In the public system increased disparities between salaries of a public system doctor and of a doctor in the social insurance system led to problems in staffing the public hospitals (24,182,185). While greater coverage in the public system allowed access by more people to services, the quality of services also dropped due to resources being channelled to the social insurance system (182,185). This was exasperated by the loss of formal employment in Uruguay over the 1990s, which also increased the number of people requiring coverage by the public system. With the gradual deterioration of public services and the growing cost of the social insurance system, private health care provision grew for the middle and upper classes, leading to a continually growing gap in the quality of care provided in the public versus the private system. As people with coverage under social

insurance were prohibited access to the public system increased co-payments to Mutual Benefit Fund members led to some people being unable to access any health care. (80;81). Overall the health system over the 1990s transformed into an increasingly stratified system in which the poor had access to a progressively deteriorating public system and the wealthy turned increasingly to a variety of private provision options.

Table 4.14: Health Reforms in the 1980s

Argentina	Uruguay
Health Expenditure ▪ Public and private health expenditure improved moderately than decreased at the end of the decade ▪ *Obras* health funds established or increased the size of co-payments	**Health Expenditure** ▪ Public health care, and social insurance funding increased
Organizational reforms ▪ Public hospitals and national health programs were transferred to the provinces ▪ Delayed budget execution	**Organizational reforms** ▪ Increased investment in public healthcare equipment, facilities, coverage and medication ▪ DISSE placed in management role over the Mutual Benefit Fund ▪ Salary contributions to Mutual Benefit Funds made proportional to salary amount.

Table 4.15: Effects of Health Reforms in the 1980s

Argentina	Uruguay
Public ▪ Health care provisions suffered dramatically (e.g. Immunization program required emergency assistance) ▪ Health care demand increased from lower/middle income households ▪ Health care capacity for long and short term care deteriorated ▪ Physician salaries decreased ▪ Fluctuations in the level and structure of public expenses caused difficulty in health planning and	**Public** ▪ Increased coverage ▪ Improved quality of medical care (e.g. immunization rate improved

service delivery	
Social Insurance (Obra Sociales) ▪ Reduced revenues from growing unemployment ▪ Size of co-payments increased	**Social Insurance (Mutual Benefit Funds)** ▪ Increased coverage
Private ▪ Increased usage ▪ Attracted physicians from public care ▪ More costly practices than necessary used ▪ Corruption by economically powerful interest groups (pharmaceutical industry)	**Private** ▪ Not Available
Co-ordination among providers ▪ Equipment, infrastructure and specialties duplicated ▪ Doctors overstaffed	**Co-ordination among providers** ▪ Not available

Table 4.16: Health Care Reforms in the 1990s

Argentina	Uruguay
Public ▪ Increased financial independence of hospitals ▪ Recovering costs from insured groups that use public facilities	**Public** ▪ Greater coverage provided ▪ Decreased funding due to increased subsidies to Social Insurance ▪ Restricted access to those already covered under Social insurance
Social Insurance (Obra Sociales) (Competition introduced) ▪ Greater freedom to negotiate contracts with providers introduced ▪ Insurance affiliates given the right to select funds ▪ Private insures permitted to compete for affiliates on an even footing	**Social Insurance (Mutual Benefit Funds)** ▪ Increased subsidies ▪ Increased co-payments to members
Private ▪ Private insures permitted to compete for affiliates on an even footing	**Private** ▪ No Reforms

Table 4.17: Effects of Health Reforms in the 1990s

Argentina	Uruguay

Coverage	
Public ▪ Coverage increased ▪ Hospitals collapsed due to shortages of essential drugs and supplies in 2001-2002 ▪ Price of drugs increased due to peso devaluation in 2001 - 2002	**Public** ▪ Increased coverage due to increased unemployment that caused people to lose coverage under social insurance
Social Insurance (Obra *Sociales*) ▪ Coverage decreased due to cost increases (copayments) ▪ Inability of social insurance to repay debts caused suspension of care by their members to pharmacies in 2001 – 2002 ▪ Price of drugs increased due to peso devaluation	**Social Insurance (Mutual Benefit Funds)** ▪ Increased coverage
Private ▪ Usage increased substantially	**Private** ▪ Increased usage by middle and upper income classes.
Inequity	
Public ▪ Targeted already insured individuals so they could recoup costs ▪ Lengthy means testing required for access ▪ Reduced quality of services due to increased coverage and reduced resources ▪ Hospitals collapsed due to shortages of essential drugs and supplies in 2001-2002	**Public** ▪ Decreased physician salaries ▪ Quality of services dropped due to lack of resources
Social Insurance (Obra Sociales) ▪ Higher income workers targeted ▪ Barriers to low income, high risk groups implemented ▪ Co-payments, nonpayment by social insurance to private providers, and confusion in assignment of provider increased barriers to access ▪ Workers lost insurance protection because of labour reforms and unemployment ▪ Inability of social insurance to repay debts caused suspension of care by their members to pharmacies in 2001	**Social Insurance (Mutual Benefit Funds)** ▪ Increasing salary of physicians in comparison to public sector ▪ Lower income decreased access to care due to growing co-payments

– 2002	
Private ▪ High income groups targeted ▪ Barriers to access increased (e.g. co-payments)	**Private** ▪ Increased usage by middle and upper income classes. ▪ Increased private provision options
Cost Containment	
Public ▪ Recouped more costs from insurance funds ▪ Increased administration charges ▪ Low income and high risk groups increased in numbers, increasing costs ▪ Hospitals collapsed due to shortages of essential drugs and supplies in 2001-2002	**Public** ▪ Expenditure on public system decreased due to increased subsidization of Social Insurance
Social Insurance (Obra Sociales) ▪ Number of insurance providers decreased, those with the highest administrative costs closed ▪ Low income and high risk groups increased, increasing costs ▪ Inability of social insurance to repay debts caused suspension of care by their members to pharmacies in 2001 - 2002	**Social Insurance (Mutual Benefit Funds)** ▪ Expenditure on subsidizing system continued to grow
Private ▪ Increased proportion of total health expenditures went to the private sector	**Private** ▪ Not available

4.6 Summary of Neoliberal Reforms and Effects in Argentina and Uruguay (1980s, 1990s)

A review of the implementation of neoliberal reforms in Argentina and Uruguay over the 1980s and 1990s reveals that generally neoliberal reforms undertaken in Argentina were more severe than in Uruguay and that greater reforms were associated with worsening conditions in most of the areas studied. In the 1980s, labour market and health care reforms demonstrate the most notable differences in the two countries' approaches, as Argentina underwent more extensive reforms in contrast to Uruguay's more moderate approach. In

both areas in Argentina, greater neoliberal reforms were also associated with declining labour market conditions and worsening health care services, while in Uruguay increased government intervention and regulation in 1985 brought improved health care services and labour market conditions. Per capita income and real wages decreased in Argentina and unemployment, precarious employment and underemployment increased. In contrast real wages in Uruguay increased and unemployment decreased. In Argentina the quality of public health care declined dramatically, social insurance experienced increased costs and reduced coverage and there was a greater reliance on the private care system. In contrast in Uruguay public and social insurance health care provision increased coverage and the quality of services improved in the public system.

Neoliberal reforms to trade undertaken in the 1980s remained moderate in both countries and had similarly disappointing results. Manufacturing declined in both countries and especially in small and medium sized firms. The limited benefits achieved in trade over the 1980s, such as the trade surplus, were only gained at the expense of an economic recession in Argentina and from bilateral trade agreements in Uruguay, rather than resulting from the benefits of increased openness to the world. Pension reform and privatization of state owned enterprises were two areas that remained most similar in both countries over the 1980s. In both countries only moderate pension reforms took place though Argentina's reforms were more significant than Uruguay's. The more severe reforms in Argentina were reflected in worsened income for pensioners in contrast to improved incomes in Uruguay in the mid 1980s though the economic sustainability of both systems continued to decline. The privatization of state enterprises was delayed until the 1990s in both countries.

Table 4.18: Summary of Neoliberal Reforms and Effects in the 1980s

Reforms			
	Trends Argentina	**Trends Uruguay**	**Relative Degree of Reforms (Argentina to Uruguay)**
Trade	Increased	Increased	Similar to Uruguay
Privatization	No reform	No reform	Similar to Uruguay
Labour Market	Increased	Increased	Greater than Uruguay
Pensions	Increased	Increased	Slightly greater than Uruguay
Health Care Systems	Increased	Decreased (increased protectionist policies)	Greater than Uruguay
Effects			
	Trends Argentina	**Trends Uruguay**	**Relative Status (Argentina to Uruguay)**
Trade	Deteriorated	Deteriorated	Worse than Uruguay
Privatization	N/A	N/A	N/A
Labour Market	Deteriorated	Improved	Worse than Uruguay
Pensions	Deteriorated	Improved	Worse than Uruguay
Health Care Systems	Deteriorated	Improved	Worse than Uruguay

Over the 1990s neoliberal reforms in both countries accelerated and in some cases became more integrated though Argentina's reforms remained more extensive than Uruguay's. Increasing neoliberal reforms in both countries over the 1990s were associated with worsening conditions with the more extensive reforms undertaken in Argentina resulting in worse outcomes. The greatest difference occurred in labour market reforms, privatization of state enterprises and health care reforms. Reforms to the labour market and the privatization of state enterprises accelerated dramatically in Argentina over the 1990s in comparison to Uruguay's more gradual pace. The structure of Uruguay's health care system

also remained largely unreformed while Argentina undertook extensive reforms by introducing competition into the health insurance sector.

With increased reforms to the labour market, conditions in Argentina continued to decline while Uruguay's previously improving labour market conditions began to deteriorate, though the situation was not as critical as in Argentina. Unemployment, precarious employment and underemployment increased in Argentina and after an initial recovery real wages also decreased. In Uruguay, unemployment increased over the entire decade and precarious employment, underemployment and real wages declined in the second half of the 1990s. Radical privatization of state enterprises undertaken in Argentina over the 1990s also had detrimental impacts. Argentina attained short-term cash for debt payments that appeased multilateral institutions, at the expense of long-term cost increases for consumers and losses of fiscal revenue from economically self-sustaining or profitable sectors. Uruguay's more gradual approach of increasing competition in rather than selling public utilities tempered some of the negative repercussions experienced by Argentina. By avoiding the temptation of short-term debt payments, the country managed to prevent increases in consumer costs and losses in fiscal revenue, although improvement in the quality of and access to services never occurred. In health care Argentina's more drastic reforms resulted in worsening fiscal problems, coverage, and inequality in access to services that culminated in a health care crisis in 2001 – 2002. In Uruguay's largely unreformed system coverage improved but inequality and costs continued to worsen though never to the degree they had in Argentina. In the light of Argentina's severe health care crisis, Uruguay's more moderate protectionist approach to reforms showed itself to be more effective at coping with the deteriorating social and economic conditions that were causing substantial stresses on the health sector.

Reforms undertaken in the area of pensions and trade demonstrate most clearly the growing convergence in policy direction in the two countries over the 1990s. Trade reforms in both countries accelerated dramatically and became assimilated under Mercosur, while pension reform accelerated with both countries adopting a mixed private and public pension system. Increased trade liberalization in both countries failed to produce the hoped for trade surplus and the marginal successes attained in trade growth were attributed more to trade with Mercosur countries rather than being the result of greater openness to the world. Manufacturing also continued to suffer in both countries over the 1990s demonstrating the continuing failure of trade liberalization to produce increased efficiency and productivity that was promised under a more competitive environment. The failure of trade liberalization in the 1990s demonstrated that achieving successful trade growth was dependent on complex and unpredictable factors such as geographical closeness, historical ties and exchange rate levels rather than being an automatic result of openness to the market. Pension reform in both countries also resulted in social and economic problems over the 1990s though Uruguay's delayed reforms mitigated some of the negative social and economic impacts. In Argentina coverage decreased, inequities increased and the system hit financial collapse in the early 2000s. In Uruguay real pensions recovered in the early 1990s but initial results of reforms implemented in the late 1990s demonstrate that they did not alleviate the growing financial costs of the system or improve coverage.

Table 4.19: Summary of Neoliberal Reforms and Effects in the 1990s

Reforms			
	Trends Argentina	**Trends Uruguay**	**Relative Degree of Reforms (Argentina to Uruguay)**

Trade	Increased	Increased	Similar to Uruguay
Privatization	Increased	Increased	Greater than Uruguay
Labour Market	Increased	Increased	Greater than Uruguay
Pension	Increased	Increased	Similar to Uruguay
Health Care Systems	Increased	Continued protectionist policies	Greater than Uruguay
Effects			
	Trends Argentina	**Trends Uruguay**	**Relative Status (Argentina to Uruguay)**
Trade	Deteriorated	Deteriorated	Similar to Uruguay
Privatization	Deteriorated	Deteriorated	Worse than Uruguay
Labour Market	Deteriorated	Deteriorated	Worse than Uruguay
Pension	Deteriorated	Deteriorated	Similar to Uruguay
Health Care Systems	Deteriorated	Deteriorated	Worse than Uruguay

Chapter 5 Cumulative Effects on Population Health

Chapter 5 compares the cumulative effects of neoliberal reforms on population health in Argentina and Uruguay over the 1980s and 1990s. The progress of the countries' economic (GDP, inflation, debt) and social determinants (poverty, inequality) and their corresponding health outcomes (IMR, <5MR) are examined with particular attention paid to improved or deteriorated trends and their status relative to the other country. The relative progress or deterioration found in the health determinants is than linked to their health outcomes creating a comprehensive picture of population health in the countries.

5.1 Economic Effects

5.1.1 Economic Growth

5.1.1.1 Argentina

In the 1980s Argentina suffered a deep recession associated with the implementation of adjustment and economic restructuring policies adopted as a result of the debt crisis. (24,116,186). Given the economic crisis being experienced Argentina was forced to generate the foreign savings necessary to pay the interest on its foreign debt by contracting domestic demand and inducing a recession severe enough to produce the necessary trade surplus (116). Over the decade Argentina underwent 5 years of negative growth including 1981 – 1982, 1985, and 1988-1989, which represented the longest period of stagnation the country had experienced in a century (116,179). The recession of 1988-1989 was the most severe of the 1980s concluding a decade of dismal economic performance (116).

Economic growth in the 1990s in Argentina improved significantly though financial collapse in 2001 has demonstrated the continuing fragility of the economy. Discounting the 1995/96 recession, the Argentinean economy over the 1990s registered rates of growth per capita last recorded at the beginning of the century (179). From 1991 to 1994 the country

averaged a GDP/capita growth rate of 9 percent per year (159). A contractionary period began in early 1995 and lasted until mid 1996 induced by the Mexican crisis in December 1994 (130). While recovery from the effects of the Mexican crisis of 1995 was fairly quick, with real GDP growth of 5.5 percent in 1996 and an impressive 8.1 percent in 1997, Argentina could not return to strong growth after the recession that followed the successive shocks from East Asia, Russia and Brazil in 1998. In 1999, following the 1998 international crisis, GDP fell by 3 percent and Argentina entered fully into recession (187). In 2001, after a decade of remarkable growth, Argentina entered into an economic crisis in which it experienced economic contraction that rivalled the U.S.'s Great Depression (188).

While the 1990s' impressive record of growth was championed by the IMF and the World Bank as a model of success, the collapse of the economy in 2001 shed new critical views on the accomplishments of this decade (188,189). Economic recovery over the 1990s has been critiqued for being debt-led growth rather than export-led growth (189). With the stabilization of the economy in 1991 and the positive external environment, huge capital inflows into Argentina occurred, leading to drastic increases in consumption and, hence, increases in GDP/capita (190). At the same time consumption was increasing domestic producers were failing to become major competitors in the international market. (189). Even though the aggregate growth rate was impressive, economic sectors and regions more exposed to foreign competition fared poorly compared to the average trend and sometimes experienced contraction (190). The poor adaptation of domestic producers to liberalization in conjunction with increased imports meant that when growth occurred it was due to a higher share of imports rather than exports, creating a vicious circle of external financing crises (189).

5.1.1.2 Uruguay

Turning to Uruguay over the 1980s it is evident that the debt crisis also had serious implications for the country, though relative to Argentina its effect on economic performance was not as devastating. Uruguay only experienced two years of recession from 1982-84, and with the return of democratic government in 1985 growth was renewed (98). From 1986-87 a strong growth performance occurred based on export demand from Brazil and Argentina (116,144). By 1988 the recovery was proving unsustainable and GDP growth ceased though it never fell to negative growth as it had in Argentina (144).

Economic growth in Uruguay over the 1990s followed a similar pattern to Argentina, with overall positive growth rates that culminated in recession at the end of the 1990s and a financial crisis in the 2000s, though it never reached the economic devastation that Argentina experienced. As with Argentina the central economic problem with Uruguay over the 1990s was the strong trade deficit that was the result of a debt led growth pattern fuelled by and highly dependent on capital inflows (191). Generally over the decade Uruguay recorded positive growth rates with an average GDP growth rate of 3.5 percent but a closer breakdown of the economic trends reveals a less optimistic picture. In the early 1990s Uruguay underwent a period of recovery with GDP growth averaging 4 percent between 1990 and 1994 (144). Following the Mexican crisis Uruguay entered into recession, with GDP declining by 2.5 percent in 1995 (192). With the help of the IMF economic activity quickly recovered, expanding by almost 5 percent in 1996 (192). This recovery lasted only until 1999 when Uruguay again entered into a deep recession due to several external factors including the devaluation of the Brazilian real, the beginning of a profound recession in Argentina, a severe drought and low commodity prices (193,194). After 1999 Uruguay

continued to suffer from its longest economic recession in recent history with GDP declining continuously since the last quarter of 1998 (194).

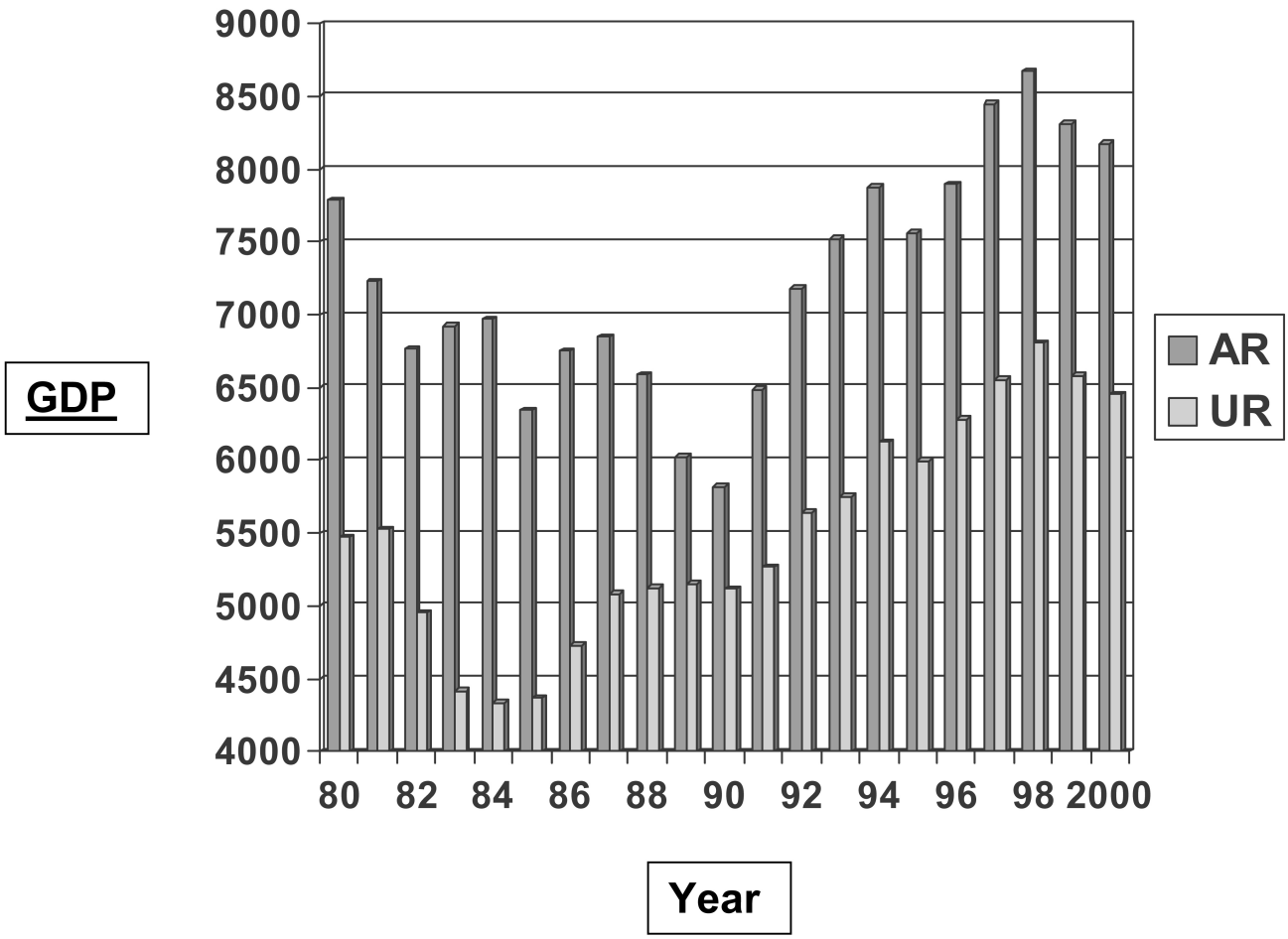

Figure 5.1: GDP Per Capita in Argentina and Uruguay

5.1 Economic Growth in Argentina and Uruguay (1980s, 1990s)

Economic Growth 1980s		
	Trends	**Contributing Factors**
Argentina	▪ Five years of negative growth (1981,1982,1985,1988,1989) ▪ Longest period of stagnation in a century	▪ Recession induced to provide necessary trade surplus to pay foreign debt
Uruguay	▪ Only two years of recession (1982-1984) ▪ Growth (1985 – 1987) with return to democracy ▪ 1988 GDP growth ceased though never turned to negative growth	▪ Growth due to demand from Argentina and Brazil
Economic Growth 1990s		
	Trends	**Contributing Factors**
Argentina	▪ High growth (1990-1994,1997-1998) ▪ 1995/96, 1999 recession ▪ 2001 economic crisis	▪ Mexican crisis 1995 ▪ International crisis East Asia, Russia and Brazil 1998 ▪ Debt led growth versus export led growth
Uruguay	▪ Growth (1990-1994, 1996-1998) ▪ Recession 1995 ▪ Recession 1998 onwards	▪ Mexican crisis 1995 ▪ Brazil devaluation, recession in Argentina, drought, low commodity prices ▪ Debt led growth

5.1.2 Inflation

Both countries suffered from high and increasing inflation rates over the 1980s, though Argentina fared substantially worse than Uruguay. Inflation in Argentina was high and gradually worsened until it culminated in a hyperinflationary period at the end of the

1980s (43). For only two years out of the decade did inflation dip below 100 percent (195). Inflation rates over the decade went from101 percent in 1980 to 672 percent in 1985, which provoked the newly elected democratic government to implement a wage-price freeze that had temporary success in bringing inflation down to below 100 percent. (43). By 1989 prices were again rising rapidly and inflation swelled to 3080 percent (43). Inflation in the 1980s in Uruguay was also high and increased over the decade though it never reached the hyperinflationary levels of Argentina (144). In contrast to Argentina inflation started the decade at 63 percent fell to 19 percent in 1982 and steadily rose until 1990 where it peaked at 113 percent. (144,163).

In the 1990s inflation in Argentina changed significantly. Under the Convertibility Plan[23] implemented in 1991 Argentina ceased to be a high inflation country (195). In the period 1991-1994 Argentina showed a dramatic decrease in inflation though it remained higher than the average international inflation rate (195). The inflation rate (over 2000 percent in 1990) was reduced to double digits in 1992, was less than 1 percent in 1996 and 1997 and became deflation in 1999 and 2000 (43,163). Inflation in the 1990s in Uruguay also fell but not as rapidly or as drastically. In the early 1990s inflation was reduced from 113 percent in 1990 to 54 percent in 1993 and fell gradually until it reached 5 percent in 2000 (163).

Table 5.2 Inflation in Argentina and Uruguay (1980s, 1990s)

	1980s	**1990s**

[23] A 1991 law that established an exchange rate between the Argentine currency and the U.S. dollar at a fixed parity of one to one (137).

Argentina	▪ High and increasing inflation over the 1980s ▪ End of the 1980s hyperinflation ▪ 1980 – 101 percent, 1989 – 3080 percent	▪ Drastically decreased to 1 percent in 1996 ▪ Deflation in 1999-2000
Uruguay	▪ High and increasing inflation though significantly lower than Argentina ▪ No hyperinflation ▪ 1980 – 63 percent, 1990 113 percent	▪ Fell gradually to 5 percent in 2000.

5.1.3 Debt

In the 1980s Argentina, like other Latin American countries, experienced a severe debt crisis. Over the late 1970s and early 1980s Argentina's debt grew rapidly leading to massive capital flight, an exchange rate crisis, devaluation and default in 1982 (196,197). Total external debt in US dollars rose from $27.16 billion in 1980 to $43.63 billion in 1982 due in part to the rise in international interest rates and the devaluation of the peso. The public sector proportion of the foreign debt also rose in these years as a result of the absorption of a considerable proportion of private sector debt that had been guaranteed by government. From 1982 to 1990, despite austerity measures and international private credit rationing, the debt kept increasing, though at a slower pace. By 1990 total external debt had reached $62.23 billion and per capita public and publicly guaranteed external debt had grown from $362 million in 1980 to $1452 billion.

The 1990s in Argentina were characterized by accelerated indebtedness that resulted in the country once again falling into financial crisis, with subsequent capital flight[24] and

[24] The movement of money from one investment to another in search of greater stability or increased returns. Sometimes specifically refers to the movement of money from

devaluation and eventual loan payment default in 2001 (196,197). Growth in the rate of indebtedness was particularly sharp after 1992 and was largely generated by the private sector, though public sector debt became a greater issue in the second half of the 1990s (196). The Brady agreement signed in December 1992, which swapped $21 billion debt to commercial banks plus $8.3 billion in late payments for 30-year Brady bonds, did not stop the debt from growing at an alarming rate (197). Total external debt rose from $68.35 billion in 1992 to $145.88 billion in 2000 and per capita public and publicly guaranteed external debt went from $1452 in 1990 to $2360 in 2000 (163). After the crisis the IMF, previous supporters of Argentina's policy reforms, blamed failures in fiscal policy for the financial disaster (196,197). Alternative views placed responsibility for the debt build up on a combination of external shocks, the privatization of the social security system and neoliberal policies supported by the IMF that were compounded by the 1998 recession. While there are a variety of views on the causes of the debt build up, it is evident that the acceleration of neoliberal reforms in the 1990s did not, as they had been intended to, prevent the financial crisis and popular revolt that brought down five governments between 2001 and January 2002.

Like Argentina the debt crisis in Uruguay was severe in the 1980s leading to capital flight though Uruguay never defaulted on its debt. Total external debt increased significantly in the early 1980s rising from $1.66 billion in 1980 to $2.65 billion in 1982, also due to rising interest rates and the depreciation of the peso (163,171). By 1990 total external debt had almost doubled to $4.42 billion. Public foreign debt also grew significantly over the early

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investments in one country to another in order to avoid country specific risk (such as inflation or political turmoil). Often the outflows from capital fight are large enough to affect a country's entire financial system.
http://www.investorwords.com/704/capital_flight.html

1980s because of the purchase of loans from failing private banks (98). By 1990 public foreign debt had reached $980.36 million from $386.75 million in 1980. While Uruguay's total external debt appears to be a fraction of the debt of Argentina a look at the per capita debt demonstrates that it was a high burden to be carried by its much smaller population. Per capita public and publicly guaranteed debt was actually higher in Uruguay than in Argentina at the beginning of the 1980s. While Uruguay started the decade with a higher per capita public and publicly guaranteed debt, by 1990 Uruguay's per capita debt was $980 while Argentina's had swelled to $1452 (163).

In the 1990s Uruguay's debt continued to increase steadily and culminated in 2002 in financial crisis shortly after Argentina's, reflecting the increased integration of their economies. Total debt in Uruguay increased from $4.42 billion in 1980 to $8.2 billion in 2000 (163). Per capita public and publicly guaranteed debt also increased substantially from $980 in 1990 to $1828 in 2000 (163). While Uruguay's debt never increased to Argentine levels the financial crisis in 2002 that triggered massive runs on the banks and street riots demonstrated the growing symmetry between Argentina's and Uruguay's economies and their fragility to external influences (171). The financial crisis was triggered by a currency devaluation in Brazil in 1999, which made Uruguayan goods less competitive, and an outbreak of foot and mouth disease in 2001 that curtailed beef exports to North America. Starting in late 2001, the economic crisis in Argentina also undermined Uruguay's economy, causing exports to Argentina and tourist revenues to fall dramatically. In mid-2002 Argentine withdrawals from Uruguayan banks started a bank run that was only overcome by massive borrowing from international financial institutions. While the mounting debt over the 1990s and financial crisis in 2003 in Uruguay never reached the extreme collapse experienced in Argentina a similar trend of debt accumulation and crisis occurred in both countries.

Table 5.3: Debt in Argentina and Uruguay (1980s, 1990s)

Total External Debt (US$ billions)			
	1980	**1990**	**2000**
Argentina	27.16	62.23	145.88
Uruguay	1.66	4.42	8.2
Public and Publicly Guaranteed External Debt (US$ per capita)			
	1980	**1990**	**2000**
Argentina	362.39	1451.72	2359.6
Uruguay	386.75	980.36	1828.25

5.2 Social Effects

5.2.1 Poverty

Poverty in Argentina over the 1980s rose very sharply, increasing in the early 1980s and skyrocketing during the hyperinflationary period in the late 1980s (67). In the Metropolitan Area of Buenos Aires the percentage of the households in poverty went from 4.9 percent in 1980 to 16.2 percent in 1990. A central cause of increasing poverty over the decade was the situation of the labour market. Over the 1980s increasing open unemployment, informal employment and especially the decline in real wages were the principal factors influencing the deterioration of living conditions in the country. In contrast to Argentina, Uruguay underwent an increase in poverty under the military government but then experienced a dramatic decline in poverty over the late 1980s with the return to democracy (198,198,199). In 1981 the percentage of households living in poverty went from 6 percent in 1981 to 9.2 percent in 1986 to 7.2 percent in 1990. Improvements in the poverty levels in Uruguay in the late 1980s were largely effected by the situation of the

labour market in which the increase of real wages and decrease in unemployment led to declining poverty rates (145).

By all indicators, poverty over the 1990s in Argentina continued to increase dramatically, if episodically. Looking at a break down of the trends over the decade, poverty fell in the early 1990s due to the dramatic reduction of inflation though it remained almost double its 1980s levels. Poverty increased between 1992 and 1996 despite a significant growth in GDP and continued low levels of inflation. After a temporary reduction around 1998 poverty increased again, fuelled by the economic recession that started in the second half of 1998 (200). While poverty levels in the late 1990s never reached the levels of 1990 the comparatively lower levels of inflation make the growth in poverty over the decade more significant than the absolute numbers reflect. ECLAC data show that the percentage of homes in poverty in the Metropolitan area fell from 16.2 in 1990 to 9.8 in 1992, increasing again to 13.1 in 1999 (200). The dramatic increase in poverty in the 1990s is more evident when considered relative to other Latin American countries; Argentina ranks third according to points of poverty increase, and first if the increase is measured in percentages (200). The growth of poverty over the decade was due to the fall of real household income associated with the recession, the deterioration in the terms of trade, and a worsening income distribution (201).

In comparison to Argentina and most other Latin American countries, Uruguay's poverty levels fared much better over the 1990s. While measurements of poverty in Uruguay are not as unified as in Argentina, most indicators show an initial decrease in poverty levels until 1992, coinciding with decreased inflation, followed by a gradual increase over the rest of the decade(199). According to ECLAC, the percentage of homes living in poverty in the metropolitan area decreased from 7.2 in 1990 to 3.7 in 1992 and then rose

again to 5.8 in 1999(99). Although Uruguay's poverty trends reflected a similar pattern to Argentina its overall levels remained significantly lower than Argentina. Uruguay also began and ended the decade with one of the lowest poverty levels in the region (199).

Table 5.4: Poverty in Argentina and Uruguay (1980s, 1990s) (Metropolitan Area, Percent Households)

	1980s	1990s
Argentina	▪ Increased dramatically (4.9 percent in 1980 to 16.2 percent in 1990)	▪ Decreased in early 1990s (16.2 percent in 1990 to 9.8 percent in 1992) ▪ Increased from 1992 onwards (9.8 percent in 1992 to 13.1 percent in 1999)
Uruguay	▪ Increased under military dictatorship (6 percent in 1981 to 9.2 percent in 1986) ▪ Decreased with the return of democracy (9.2 percent in 1986 to 7.2 percent in 1990)	▪ Decreased in early 1990s (7.2 percent in 1990 to 3.7 percent in 1992) ▪ Increased moderately (3.7 percent in 1992 to 5.8 percent in 1999)

Table 5.5: Poverty Rates (Percent) in Argentina and Uruguay (1980s, 1990s)

	1980, 1981	1986	1990	1992	1999
Argentina	4.9	Continued increasing	16.2	9.8	13.1
Uruguay	6	9.2	7.2	3.7	5.8

5.2.2 Inequality

In examining inequities Argentina and Uruguay provide an interesting comparison as traditionally they have been two of the most equal countries in Latin America (200). Following the debt crisis and the deepening of neoliberal reforms over the 1980s the once almost identical countries began to drift apart. As Argentina implemented more drastic reforms over the 1980s its income distribution began to worsen while Uruguay's more moderate implementation of reforms corresponded with decreased inequities. Despite beginning the 1980s at a relatively low level of inequality in comparison to other Latin American countries, by the end of the 1980s Argentina's income distribution had deteriorated to a moderately high rate. The Gini coefficient (a measure of income inequality in which zero equals perfect equality and one equals perfect inequality) for Argentina was 0.365 in 1980 and 0.423 by 1990 with most of this increase occurring during the macroeconomic crisis of the late 1980s (99,200,202). Argentina's worsening inequality during the 1980s was connected to the reduction of real wages in conjunction with growing inequality in the dispersion of wages. Not only did real wages decrease over the 1980s but decreases were more extreme in the lower income groups than in the highest income groups, which experienced relatively little loss (201).

In contrast to Argentina, Uruguay's inequality at the beginning of the 1980s was slightly worse but by the end of the 1980s had become more equitable. The Gini coefficient for Uruguay fell from 0.379 in 1981 to 0.353 in 1990 (99,199). Differences between the two countries' income distribution can be attributed largely to the differing situation of their labour markets over the decade. In Uruguay's labour market the opposite trend to Argentina can be seen in which the recovery of real wages and pensions after the return to democracy resulted in a slight improvement in the distribution of incomes(145,201,203). Over the

1980s, then, a dramatic shift can be observed in which Uruguay's income distribution improves at the same time that Argentina's worsens, reversing their starting positions.

Unlike the 1980s, Argentina and Uruguay both experienced increases in inequality over the 1990s, although Argentina's income distribution deteriorated at a greater pace and to a larger extent then in Uruguay and Uruguay's inequality improved before worsening at the end of the decade. All measures of income inequality over the decade show the same increasing pattern in Argentina. The Gini coefficient, for instance, increased from 0.423 in 1990 to 0.439 in 1994 where it stayed until 1997 and then increased substantially at the end of the decade (200,204). It is important to recognize that it was not only the poor but also the middleclass that suffered a drop in their share of per capita income (200). The income share of the bottom 7 deciles all fell over the decade; the poorest decile's share of national income fell from 1.8 percent in 1992 to just 1.2 percent in 2000. On the other end of the income spectrum, the richest decile saw its share of national income increase from 34.1 in 1992 to 37.4 in 2000.

Uruguay also experienced increasing inequality over the 1990s, though the shifts in the distribution of wealth were not as drastic and were preceded by improved equality during the first part of the decade. The Gini coefficient in Uruguay improved marginally from 0.353 in 1990 to 0.3 in 1994 where it stayed until 1997 before worsening again in 1998 (199). Similar to Argentina, the share of national income in Uruguay increased for the wealthiest income groups while decreased in the middle to poorest groups, though these changes were small in comparison to Argentina's (199). The poorest decile's share of national income, for example, went from 1.8 percent in 1992 to 1.7 percent in 2000, while the richest decile experiences an increase from 31.6 percent in 1992 to 33 percent in 2000 (199).

Both countries experienced a growth in inequality that coincided with intensified neoliberal reforms during the decade; the substantial difference in the magnitude of the changes in inequalities they experienced also correlate with the differences in how extensively the countries implemented those reforms. Income inequality in Argentina in the 1990s rose more than in any other Latin American country (96,202) while income distribution in Uruguay remained the most egalitarian in Latin America, despite increasing at the end of the 1990s (199,201,205).

Table 5.6: Gini Coefficient In Argentina and Uruguay (ECLAC)

	1980/1981	1990	1994	1997	1998
Argentina	0.365	0.423	0.439	0.439	Significantly Worsened
Uruguay	0.379	0.353	0.3	0.3	Significantly Worsened

5.3 Health Effects

5.3.1 Infant/Under 5 Mortality Rates

IMR and <5MR in both countries generally continued to improve during the 1980s and 1990s (163). This improvement was not surprising given that IMR and <5MR are determined by the accumulation of a wide variety of factors that are a result of past improvements, such as the number of public hospitals and doctors per inhabitant, improved water and sanitation, higher educational attainment and inoculations (67). Given the difficulty in separating the effects of past developments on current health status a more sensitive measure of changes in health requires examining not just improvements in these indicators but also their rate of reduction. Although Uruguay had a higher IMR at the beginning of the 1980s, by 1990 Uruguay's IMR was lower than Argentina's (Figure 5.2 and

5.3). Over the 1980s Argentina's IMR fell by 24.2 percent while Uruguay's fell by 45.95 percent, almost double the rate of decline as Argentina's (Table 5.6). <5MR presents a similar picture; Uruguay began the decade with a higher <5MR than Argentina but by 1990 its rate was below that of Argentina's. Argentina's <5MR decreased by 26.3 percent from 1980 to 1990 almost half of the 42.9 percent decrease that took place over the decade in Uruguay (Figure 5.5 and 5.5).

A very different picture of health emerged in the 1990s. Despite Uruguay's comparatively better rates of IMR and <5MR from 1990 to 2000, percent differences show that Argentina's IMR decreased by 28 percent and Uruguay's by 25 percent demonstrating that the rate of improvement in Uruguay's IMR was declining and becoming more similar to Argentina's (Figure 5.2 – 5.5 and Table 5.6) (163). Similarly over the same period Argentina's <5MR decreased by 28.6 percent and Uruguay's by 29.2 percent, repeating the pattern of a diminished rate of reduction in Uruguay and a greater mirroring of reduction rates in Argentina (Table 5.6).

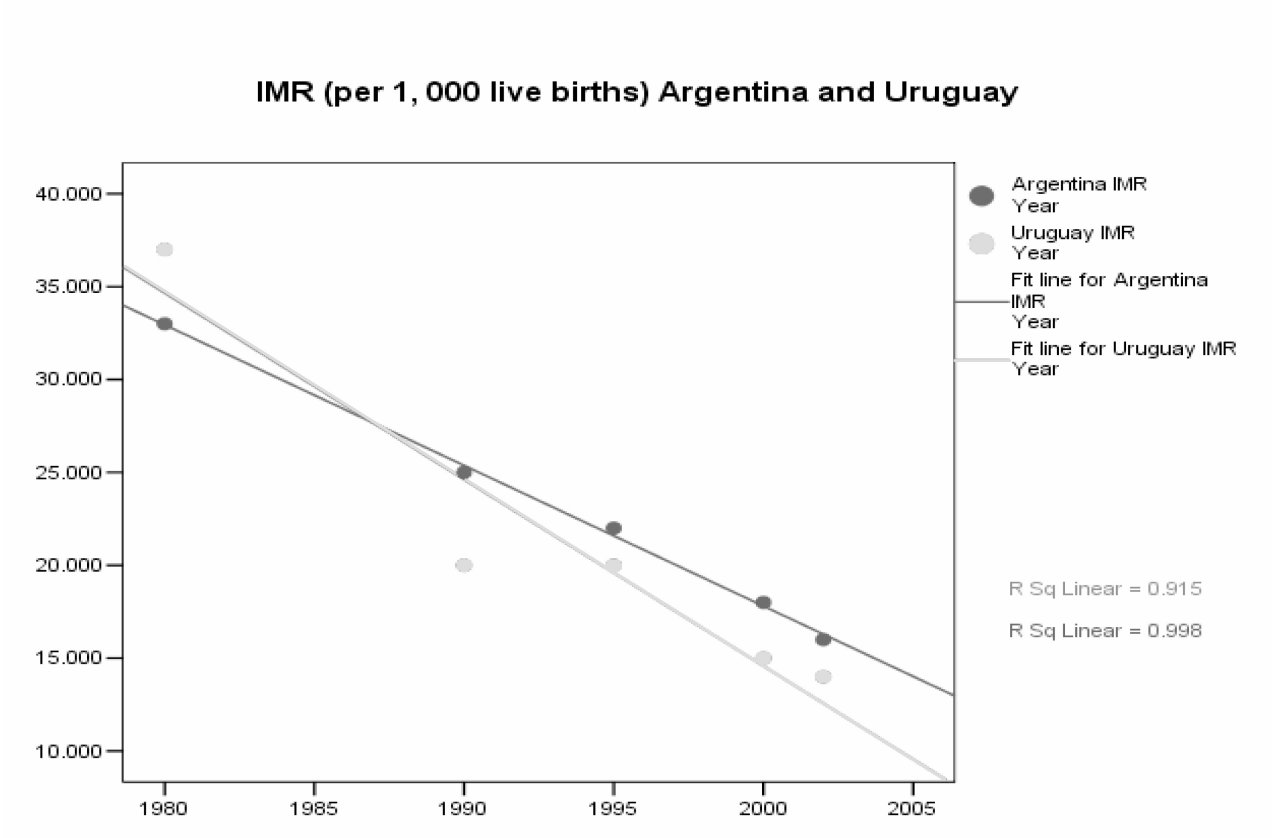

Figure 5.2: Infant Mortality Rates Argentina and Uruguay

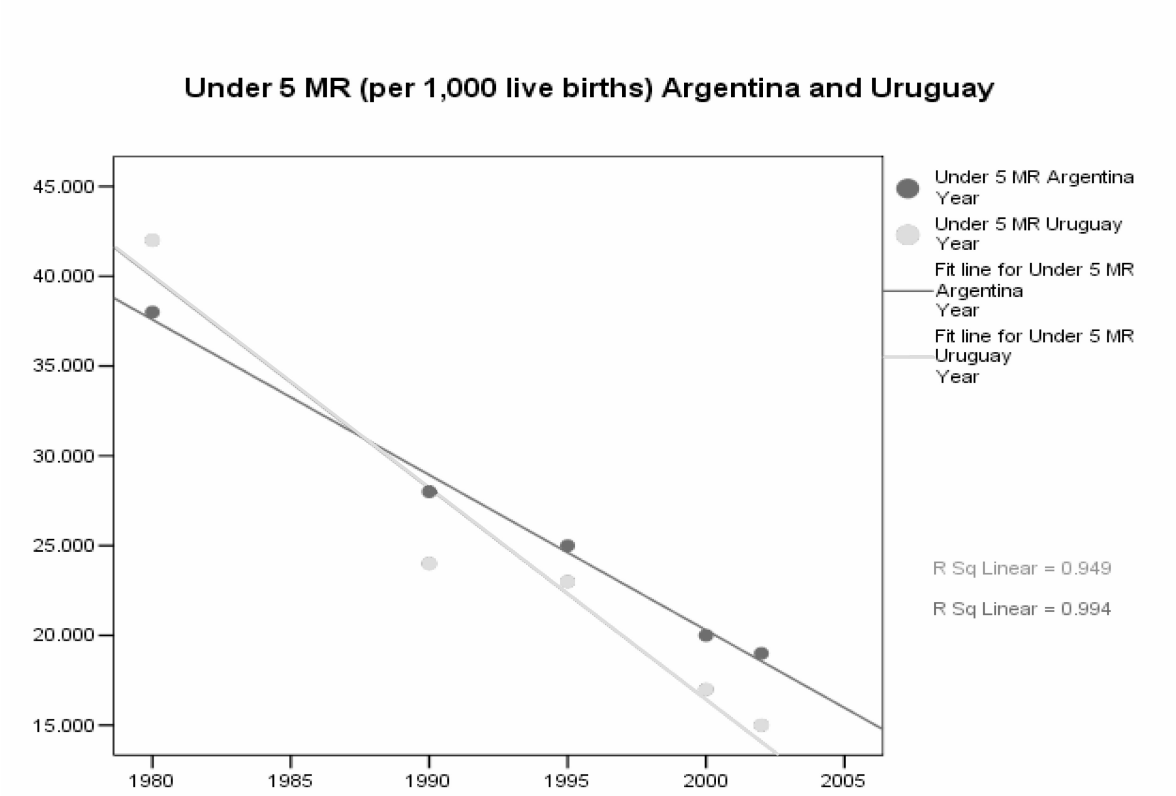

Figure 5.3: Under 5 Mortality Rates Argentina and Uruguay

Table 5.7: Infant and Under Five Mortality Rates Percent Difference

Indicator	Country	1980 - 2000	1980 - 1990	1990 - 2000
IMR	**Argentina**	45.5 percent decrease	24.2 percent decrease	28 percent decrease
	Uruguay	59.5 percent decrease	45.95 percent decrease	25 percent decrease
Under 5 MR	**Argentina**	47.4 percent decrease	26.3 percent decrease	28.6 percent decrease
	Uruguay	59.5 percent decrease	49.9 percent decrease	29.2 percent decrease

5.4 Cumulative Population Health Summary

An examination of the cumulative population health in the countries revealed that Uruguay's progress over the 1980s was generally better than Argentina's. In contrast in the

1990s population health indicators showed Uruguay's health deteriorated and became more aligned with Argentina's though it maintained a better relative level of health. An analysis of the determinants of health confirmed and strengthened the findings of the health outcomes. General progress of the countries' economic and social determinants of health were reflected in better rates of reduction and lower levels of IMR and <5MR and general deteriorations in the health determinants corresponded to slower rates of reduction and higher levels of IMR and <5MR.

Chapter 6: Reflecting on the Progress of Neoliberal Reforms in Argentina and Uruguay

This Chapter discusses the effects of neoliberal reforms in Argentina and Uruguay on the cumulative population health of the countries during the implementation of SAPs. Comparisons between the differences in degree and pace of reforms in the countries and the progress of their population health are made. The discussion draws on the literature and data analysis of reforms in Chapter 4 and the data analysis of the cumulative population health in Chapter 5 to illustrate key findings and patterns highlighted by the study. The Chapter concludes with a summary of the major conclusions, the implications for future research of neoliberal economic globalization, an overview of the strengths and weaknesses of the study and a short reflection on the experience of carrying out this research.

SAPs have made a long lasting and deep impression on Latin America (4,4-6,49). As one of the most indebted regions in the world Latin America was propelled into the hands of IFIs which restructured the economy on a neoliberal model. The role of the state with all its progressive economic and social welfare functions was sharply reduced and the economies were opened via trade and financial liberalization to the unimpeded forces of world market competition. Since the implementation of SAPs mounting evidence of growing poverty, inequality, economic crises and declining health challenge the appropriateness of continuing to implement neoliberal policies.

Despite this evidence, the debate over the success or failure of SAPs has been in some regards a difficult argument to win. SAPs, as already noted, have not been implemented in a way that reflects a pure neoliberal model (37). Often countries have progressed toward neoliberalism in an erratic manner, for instance, liberalizing their finances and trade before tackling less popular reforms in their social systems. This unplanned and

often incomplete adoption of neoliberal policies allows neoliberal advocates to dismiss the problems of countries who are in the process of adopting such reforms. In the context of economic collapse and growing poverty the fault is often placed on the partial adoption of neoliberal prescriptions (4). Even in situations in which countries have been 'model patients' economic and social problems are written off as unfortunate but necessary short term transitional costs (4,5). In this debate, in which the cure is always more time and more reforms, the comparison of the progress of Argentina and Uruguay who adopted neoliberal reforms to different degrees and at different paces is particularly useful. The following section provides this study's conclusions by answering the research question: *How did SAPs and the attendant domestic policy reforms in the 1980s and 1990s affect the population health of Argentina and Uruguay?*

6.1 Argentina and Uruguay: The Tortoise and the Hare

The progress of the two countries on cumulative population health was generally found to reflect the severity of and speed with which neoliberal reforms were implemented. The greater the speed and severity of the reforms adopted, the worse the cumulative population health effects. The greatest differences between the countries were found during the 1980s, mirroring the more rapid and intense implementation of neoliberal reforms in Argentina in comparison to the more gradual and modest reforms undertaken in Uruguay. In the 1990s, differences in the effects of neoliberal reforms on population health were reduced as Uruguay's adoption of neoliberal reforms accelerated and became more integrated with Argentina's. Even so, the more moderate approach to reforms in Uruguay in the 1990s coincided with that country's better overall population health effects.

6.1.1 1980s: A Case of Less is More.

Argentina in the 1980s experienced extensive labour market and health care reforms, moderate trade and pension reforms. In contrast, Uruguay undertook only moderate labour market, pension and trade reforms and increased its protectionist policies in health care. Coinciding with the accelerated reforms Argentina experienced severe economic stagnation over the 1980s, including 5 years of negative growth. In contrast economic recession in the early 1980s in Uruguay reversed to economic growth in 1985. While Uruguay's growth ceased at the end of the decade it never turned to negative growth as it did in Argentina. Inflation in the 1980s also showed a bleaker picture for Argentina. Inflation started high, increased dramatically and ended the decade in a hyperinflationary period. In Uruguay inflation also started high but fell in 1982 increasing toward the end of the decade but never reaching hyperinflation as it had in Argentina. Debt in both countries also increased over the 1980s, but more rapidly in Argentina than in Uruguay. Public and publicly guaranteed debt per capita in Uruguay was actually greater than Argentina at the beginning of the decade but finished the decade at a lower level.

Social indicators over the 1980s show a similarly worse pattern for Argentina than Uruguay. Although at the beginning of the decade Argentina had slightly better levels of income inequality, Uruguay's inequality declined while Argentina's increased so that by the end of the decade Uruguay had lower levels than Argentina. Similarly poverty in Argentina increased over the 1980s, while in Uruguay poverty decreased with the return to democracy in 1985 and ended the decade at a lower level than Argentina.

Corresponding to the deteriorated economic and social determinants in Argentina health indicators reflect a worse situation for Argentina. Argentina began the decade with lower IMR and <5MR compared to Uruguay but by the end of the decade the opposite was

the case. Percent decreases demonstrated that during the 1980s Uruguay's <5MR and IMR decreased at almost twice the rate of Argentina's.

6.1 Neoliberal Reforms and Cumulative Population Health Effects in the 1980s

Neoliberal Reforms 1980s			
	Trends Argentina	**Trends Uruguay**	**Relative Degree of Reforms (Argentina to Uruguay)**
Trade	Increased	Increased	Similar to Uruguay
Privatization	No reform	No reform	Similar to Uruguay
Labour Market	Increased	Increased	Greater than Uruguay
Pensions	Increased	Increased	Greater than Uruguay
Health Care Systems	Increased	Decreased (increased protectionist policies)	Greater than Uruguay
Cumulative Population Health Effects 1980s			
	Trends Argentina	**Trends Uruguay**	**Relative Status (Argentina to Uruguay)**
Growth	Deteriorated	Improved	Worse than Uruguay
Inflation	Deteriorated	Deteriorated	Worse than Uruguay
Debt	Deteriorated	Deteriorated	Worse than Uruguay
Inequality	Deteriorated	Improved	Worse than Uruguay
Poverty	Deteriorated	Improved	Worse than Uruguay
	Relative Trends (Argentina to Uruguay)		**Relative Status (Argentina to Uruguay)**
Infant MR	Slower rate of reduction than Uruguay		Higher rate than Uruguay
Under 5 MR	Slower rate of reduction than Uruguay		Higher rate than Uruguay

6.1.2 1990s: A Case of Less Would Have Been More

In the 1990s as neoliberal reforms began to accelerate in both countries and as Uruguay's reforms became more aligned with Argentina's, the population health of the countries worsened and began to more closely resemble each other. While conditions

worsened in both countries overall Uruguay's economic, social and health indicators remained better than Argentina's reflecting the more moderate reforms undertaken in Uruguay. In Argentina trade, privatization, labour market, pension, and health care reforms all accelerated drastically in the 1990s. In Uruguay trade and pension reforms accelerated most drastically and became more aligned with Argentina. Privatization was initiated in the 1990s and labour market reforms increased though both of these reforms were more moderate than Argentina's. Health care reform in Uruguay varied the most from Argentina's, as it increased its protectionist policies rather than introducing neoliberal reforms.

In general accelerating neoliberal reforms over the 1990s coincided with continuing economic problems although some of the economic indicators showed significant improvements. Argentina and Uruguay experienced markedly reduced inflation over the 1990s and improved economic growth but debt continued to grow rapidly in both countries. In addition to continued problems with debt growth, economic growth in the 1990s in both countries was also critiqued for being debt led rather than reflecting a genuine improvement in the economic situation of the countries as was evidenced by its culmination in recession in the late 1990s and economic crisis at the turn of the century. In general, economic determinants of health in Argentina and Uruguay over the 1990s showed similar trends though Uruguay fared somewhat better than Argentina. Uruguay maintained lower public per capita debt and the economic crisis in Uruguay in the 2000s never reached the financial collapse experienced in Argentina.

Over the 1990s social determinants show a deteriorating trend in both countries as neoliberal reforms increased and became more integrated. Argentina's more rapid and extensive reforms were also connected to worse social outcomes than in Uruguay. Inequality in Argentina increased in the early 1990s, levelled off and then worsened again

dramatically at the end of the 1990s. In comparison Uruguay's inequality improved in the early 1990s with reduced inflation, levelled off and then significantly worsened at the end of the decade, though it remained considerably lower than Argentina's. Poverty levels in both countries decreased until 1992 due to decreased inflation and then increased over the rest of the decade though Uruguay's poverty levels remained much lower than Argentina's.

Health indicators over the 1990s repeat the pattern of economic and social determinants. Differences in IMR and <5MR between the countries diminished over the decade and the rate of decrease of Uruguay's indicators slowed down to a similar pace as Argentina's. Despite growing similarities in the countries' health indicators, Uruguay's IMR and <5 MR remained lower at the end of the decade reflecting the more moderate reforms undertaken in Uruguay.

6.2 Neoliberal Reforms and Cumulative Population Health Effects in the 1990s

Neoliberal Reforms 1990s			
	Trends Argentina	**Trends Uruguay**	**Relative Degree of Reforms (Argentina to Uruguay)**
Trade	Increased	Increased	Similar to Uruguay
Privatization	Increased	Increased	Greater than Uruguay
Labour Market	Increased	Increased	Greater than Uruguay
Pension	Increased	Increased	Similar to Uruguay
Health Care Systems	Increased	Continued protectionist policies	Greater than Uruguay
Cumulative Population Health Effects 1990s			
	Trends Argentina	**Trends Uruguay**	**Relative Status (Argentina to Uruguay)**
Growth	Improved (Debt led)	Improved (Debt led)	Worse than Uruguay
Inflation	Improved	Improved	Better than Uruguay
Debt	Deteriorated	Deteriorated	Worse than Uruguay

Inequality	Deteriorated	Deteriorated	Worse than Uruguay
Poverty	Deteriorated	Deteriorated	Worse than Uruguay
	Relative Trends (Argentina to Uruguay)	**Relative Status (Argentina to Uruguay)**	
Infant MR	Similar rate of reduction as Uruguay	Higher rate than Uruguay	
Under 5 MR	Similar rate of reduction as Uruguay	Higher rate than Uruguay	

6.2 Conclusion

This study supports the findings of previous research that demonstrated that countries that have maintained more protectionist economic, social and health policies while applying SAPs have been better able to protect the health of the most vulnerable sectors of society. The neoliberal promise of economic growth and stability leading to poverty reduction and improved health was contradicted by Uruguay's and Argentina's experience. The failure of neoliberal policies in this case study was not due to the incomplete adoption of SAPs, as the more extreme and rapid reforms undertaken in Argentina proved to be more socially and economically destructive. Rather than validating the predominant view that welfare states are to blame for problems this study found that social safety nets and government interventions protect countries from negative health impacts while neoliberal reforms were associated with decreasing health status.

The use of a comparative case study and the globalization and health framework in this study of SAPs also demonstrates a useful methodological approach for future studies of neoliberal policies present in PRSPs and implicit in the conditions put on other ongoing debt, trade, aid and credit negotiations (7,17,17). As critiques of SAPs specifically and neoliberal policies generally accumulate, modifications to neoliberal approaches have been adopted in an attempt to address their shortcomings without substantially changing their

basic economic approach (5,37). PRSPs, for instance, purport to address poverty by better integrating the poor into the market economy through passive methods such as increased monitoring of impoverished populations (14). Poverty reduction, though, essentially remains a repercussion of market-driven growth rather than being a focus of these strategies. PRSPs remain silent to the problems of unequal market power, consolidating corporate power, restricted migration and access to rich country economies, and of local political inequalities (e.g. elite co-option, under regulated monopolies, rising global and local inequality). These programs also do not deviate from SAPs approach of imposing standardized policies on diverse country contexts (14). PRSPs' proposed 'country ownership' of economic programs has meant little more than government acceptance of IFI-promoted policies rather than a national consensus developed around a home-grown policy program (5). Further case studies of ongoing neoliberal policies can reveal if these superficial modifications are able to alter the detrimental economic, social and health effects that have been noted by this and other studies.

6.3 Strengths and Limitations

A number of strengths and limitations were encountered in this study. A key strength of the study was its comprehensive approach. The study incorporated multiple sources of data from interdisciplinary sources that encompassed key health determining pathways from the macroeconomic to the individual level. This broad approach provided a rich understanding of the complex ways by which SAPs affects health. Comparing two countries through the use of comparative historical analysis also allowed for changes in the countries economic, social and health outcomes to be more meaningfully understood as they could be compared relative to the other countries progress. The comparative case study further helped to highlight the neoliberal policies implemented under SAPs as the cause of

the changes as another country experiencing similar contexts but different policies was found to have different outcomes. Finally, the interdisciplinary population health approach of the study also created a more rounded understanding of the policy implications of SAPs by examining health through a political, economic and social lens.

While using multiple data sources, comparative methodology and an interdisciplinary approach provided a well-rounded examination of the effects of SAPs on health it also created many logistical and theoretical difficulties. Choosing appropriate data sources and integrating multidisciplinary literature into a cohesive argument required extensive expertise in historical, economic, social and political disciplines. In order to supplement my academic background in health, English and conflict resolution, committee members with backgrounds in Latin American history, economics and health were chosen. Despite this interdisciplinary committee the challenges of understanding economic data and literature, and the historical contexts of the countries in the depth and detail necessary for this study, limited the conclusions and interpretations that may have been made by someone with a broader knowledge of all these areas.

Conducting retrospective global health research in LMICs from outside of the countries studied also had many challenges in obtaining reliable and comparable data. As SAPs were implemented over 25 years ago in LMIC contexts published data sources and literature were difficult to obtain. Data collection methods were less rigorous in LMICs than would have been encountered in high income countries, the 1980s had greater technological limitations and accessing data from a distance limited the ability to assemble information. In particular disaggregated data on a broad spectrum of health outcomes were difficult to access, precluding more in depth interpretations of the health effects of SAPs on different income, gender, ethnic or age groups. Attempts to overcome this limitation were made with

limited success by spending three weeks at the Pan American Health Organization (PAHO) in Washington D.C. Many challenges were encountered in searching for data such as old computers containing data that had been shut down and moved to storage and many hard copies from countries that had been destroyed due to lack of library space. Data that was found was often not collected in a consistent manner with other countries or over the twenty year time period in which SAPs were implemented, making a comparison or interpretation of trends over time impossible. Attempts to visit the World Bank or have information couriered to PAHO from the World Bank also failed due to the post 9-11 "red alert" status of the organization. In addition, many people working with health data in Argentina and Uruguay were contacted, which produced numerous promises of information but little actual usable material.

Another difficulty in the study arose from the language barrier and the lack of lived experience in the countries studied. Many of the data sources and some of the literature in the study were in Spanish. While I have an intermediate level of Spanish, reading and understanding obscure economic terminology was often a struggle. Trying to understand the political, economic and social context of countries that I have never visited was also difficult. Having lived in other Latin American countries helped me to better understand Argentina and Uruguay as they share some cultural and historical similarities, but also led me sometimes to make incorrect assumptions or over generalize from my previous experiences.

Finally a general challenge I experienced in doing global health research for the most part in the isolation of a grad students study lounge or my home office was remaining excited and passionate about the work I was doing. Despite the sometimes dry and disconnected work required by this research the process provided me with invaluable personal learning on issues close to my heart. Having a lived experience of the hardships

faced by people in Latin America this study allowed me the opportunity to reflect on and explore the broader political, economic and social issues that contributed to the suffering I encountered there. In addition to my personal development, I hope also that this research is useful to global policy advocates and decision makers and contributes to the growing body of global policy research.

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